A MESSAGE
ABOUT THIS REPORT

A Catalyst for Improving Healthy Childhood Development in our Region
We know that a child’s healthy development—beginning with the mother’s health—lays the groundwork for a lifetime of health and well-being. When children’s physical and emotional needs are met and strengthened by positive early experiences at home and in their social and physical environments, they have greater potential to grow into healthy and successful adults. Healthy and successful adults, in turn, are the cornerstone of vital and productive communities. Simply put, if we care about the future prosperity, sustainability and well-being of our Health Region residents, it will be clearly reflected by actions and policies that give our children a healthy start.

On behalf of the Chief Medical Health Officer Saskatoon Health Region, the Public Health Observatory worked with researchers from the Healthy Children program of the Saskatchewan Population Health and Evaluation Research Unit to develop this report. It provides a balance of data, evidence-based literature, and stakeholder perspectives about the health and development of children ages 0 to 6 living in Saskatoon Health Region. The report presents the information through various lenses to inform action. For example, we report on a range of indicators by geography, socio-economic and cultural status where appropriate. We have also included selected highlights reflecting what we heard during stakeholder consultations and examples of programs and services addressing areas of concern in early childhood health and development. Based on the evidence, we include a set of recommendations which we believe, if adopted by Regional Intersectoral partners, community organizations and government, could go a long way to improving outcomes for children.

**Important Findings**

A key finding of this report, based on Early Development Instrument scores, is that 30% of kindergarten-aged children in our Health Region are vulnerable in at least one developmental area, including physical health and well-being, social competency, emotional maturity, language and cognitive development, and communication skills. This means that many children are not getting a healthy start. This indicator and several others revealed significant health inequities in children living in the most deprived areas of Saskatoon and also among First Nations and Métis children. While there is some overlap among these groups, it is important to recognize that proposed solutions are complex. For example, just as the causes of poverty are complex, requiring us to look at many areas, such as how to improve policies of income distribution, education, employment, housing and food security, so too are the root causes of First Nations and Métis health inequities. As one expert suggests “these health inequities can only be understood and intervened upon if

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i More details about the consultation process can be found at www.saskatoonhealthregion.ca/PHO

ii Areas identified as having the lowest socio-economic status based on the following bundle of indicators: education, employment levels, average income, living arrangements, marital status and proportion of single parent families.

iii The term “Aboriginal” is used within this report when describing findings from data sources that specifically use the term Aboriginal. Within the local context, the term Aboriginal is used to primarily refer to First Nations and Métis peoples, given the geography and demographic composition of Saskatoon Health Region. Nationally, however, the term Aboriginal includes all of Canada’s first peoples including First Nations, Métis, and Inuit peoples.
understood as holistic challenges.” While our First Nations and Métis communities have tremendous strengths, they also face challenges, and we need to understand the deeply rooted causes for why First Nations and Métis children continue to experience health inequities. These causes stem from a history of colonialism that has rippled across generations. The result has been a complex variety of historical, social, political and economic influences that have led to institutionalized racism, higher rates of poverty, barriers to health care and increased vulnerability to stress, all of which contribute to a greater burden of physical and mental disease and shortened life expectancy. We must all come together to change this.

What’s Needed? A Proposed Way Forward and Call to Action

Monitoring children’s health and well-being is an important first step in identifying strategies to decrease health inequities and increase future chances of success for all children. In addition to the many indicators included in this report, future measures should include a focus on strength-based outcomes.

The recommendations in this report are based on regional, provincial, national and international evidence and the advice of many local organizations and individuals. The recommendations call for a province-wide, multi-sector, multi-partner early childhood health and development strategy. Work with, and led by, First Nations and Métis partners will be critical to the strategy’s success. The strategy should be based on prevention and health promotion as a foundation and recognize the range of needs of the Region’s children. The recommendations focus on investments and improved policies, programs and services and encourage commitment for collective action from an array of stakeholders, including government and businesses. Strategic investments in communities and in public health that create the conditions for all families to raise healthy children are paramount. Investments that focus on prevention and health promotion in the early years will help reduce the social and economic burden of illness, not only in childhood but also throughout the adult years. This approach could be the single most important strategic investment we as a society could make to ensure a prosperous future. Most importantly, it is the right thing to do.

We believe that a good measure of initial success would be improving Early Development Instrument (EDI) outcomes by working together to reduce the 30% vulnerable score to 18% by 2018. “18 by 18” is a target well worth achieving and a start for further success in future years. We look forward to working together with our partners to give children in Saskatoon Health Region the best possible start.

Dr. Cory Neudorf, Chief Medical Health Officer
Saskatoon Health Region

Dr. Nazeem Muhajarine, Professor, Community Health and Epidemiology
Saskatchewan Population Health and Evaluation Research Unit

Socio-economic status is reported using different measures:

> **The Deprivation Index** is a tool used to monitor socio-economic inequalities in health and divides the Saskatoon population into five areas, or “quintiles of deprivation,” from lowest deprivation (Quintile 1) to highest deprivation (Quintile 5). Briefly, the bundle of “deprivation” variables includes education, employment levels, average income, living arrangements, marital status and proportion of single-parent families.

> **Core neighbourhoods** are made up of six contiguous neighbourhoods with the highest levels of poverty (over 30% of the population living below Statistics Canada’s low-income cut-off) while affluent neighbourhoods are those with the lowest levels of poverty. Middle income neighbourhoods make up the rest.

Geographic areas:

> **Rural Planning Zones** (RPZ) include Saskatoon and area (i.e. bedroom communities of Saskatoon), Rosthern and area, Humboldt and area, and Watrous and area.

Aboriginal ancestry is reported by two measures:

> A person of **Registered Indian Status** (RIS) means that the person is registered under Section 6 of The Indian Act. It does not include people of Métis or Inuit heritage or those of Aboriginal ancestry who are not registered; therefore, it is an underrepresentation of the total Aboriginal population.

> **Self-identified Aboriginal ancestry.**

Early Development Instrument (EDI) and “Readiness to learn:”

> **The Early Development Instrument** (EDI) is a population-level indicator of early childhood development in five key domains: physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge. Scoring low on any one of the domains suggests that students are entering kindergarten without the skills needed to learn.
**SETTING THE CONTEXT**

A child’s readiness to learn is the single strongest predictor of academic success in early grades. Subsequently, success in early grades is a strong predictor for high school completion, and measures to improve children’s readiness to learn in kindergarten are protective against both premature drop-out (before completing high school) and adolescent delinquency. What it boils down to is children who are successful in school tend to be successful in other parts of their lives – maturing into successful adults.¹

30.1% of kindergarteners in the Health Region were falling behind their peers developmentally and considered “not ready for school” at time of school entry from 2008 to 2011.

> Results were the same between urban and rural areas but vast differences were found at the neighbourhood level in Saskatoon with the percentage of children considered not ready for school ranging from a low of 10% in some neighbourhoods to a high of 56.7% in others.

**EARLY CHILDHOOD DEMOGRAPHICS**

The overview of the population ages 0 to 6 incorporates population count, population growth and family characteristics.

Children ages 0 to 6 made up almost 9% of the Health Region’s population in 2011.

> Children ages 0 to 6 made up 8.8% (27,933) of the Health Region’s population in 2011; this was an increase from 8.4% (25,390) in 2009.

> 72% lived in Saskatoon; 28% lived in rural communities.

> Almost 25% of children in Saskatoon lived in areas of highest deprivation.

The birth rate is increasing.

> In 2009, the birth rate was 13.5 per 1,000 residents, the highest since 1995, and has been increasing since 2004.

> The Registered Indian Status (RIS) population has birth rates up to three times higher than the non-RIS population (33.4 per 1,000 residents compared to 12.3 per 1,000 residents in 2009).

> By geography, the highest birth rates (17 per 1,000 residents) are among those living in areas of highest deprivation in Saskatoon.
The number of newcomer children ages 0 to 6 has increased sevenfold since 2005.

> There has been a significant annual increase in the number of immigrant children arriving in the Health Region between 2005 (44) and 2010 (302).
> 98% of these newcomer children settled in Saskatoon.
> Refugee children made up 13.7% of newcomers to the Region.

Rates of single-parent families vary by geography.

> 16.4% of families in the Health Region were headed by single parents, similar to provincial and national averages (2006), but there were geographical differences:
  
  - Saskatoon: 19.3% of families were headed by single parents (15.6% of which were female-headed, single-parent families).
  - Core neighbourhoods, Saskatoon: 36.8% of families were headed by single parents.
  - Rural areas: 9.8% of families were headed by single parents.

> Newly released 2011 Census data showed that the percentage of single-parent families in Saskatoon had decreased to 17.8% (14.3% of which were female-headed).

There has been more attention to the needs of children in care in recent years.

> The provincial Cabinet Committee on Children and Youth and other agencies are taking direct action to address the needs of this vulnerable group.

**EARLY CHILDHOOD PHYSICAL HEALTH**

Physical health goes beyond the absence of disease to include healthy birth weight, breastfeeding, risk-free pregnancies, oral health, obesity and physical environment. The chapter also looks at the leading causes of health system contact (deaths, hospitalizations and emergency department visits).

In Saskatoon Health Region, 14% of children rated low on the physical health and well-being domain of the EDI.

> The percentage of children with low scores varied greatly among Saskatoon neighbourhoods, ranging from 3.6% to 37.2%.

Infant mortality rate has remained relatively unchanged for the past decade.

> The infant mortality rate in the Health Region was 5.8 per 1,000 live births (using a 3-year average from 2007-2009).
> It was slightly higher than the national rate but just below the provincial rate.
> The 2007-2009 rate was considerably lower than the 1993-1995 rate of 9.0 per 1,000 live births.

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i Based on 2006 Census, most recent year of data available.

The lowest rates were seen in 2002-2004 (4.4 per 1,000 live births).
Since 2003-2005 the rate has remained relatively unchanged.
Differences by geography and socio-economic status persist. The infant mortality rate between 2000 and 2009 combined was:
- 6.1 deaths per 1,000 live births among Saskatoon residents compared to 4.6 for rural Health Region residents.
- About 1.5 times higher in the core neighbourhoods of Saskatoon compared to the middle-income neighbourhoods.
In 2007-2009, the Registered Indian Status (RIS) and non-RIS populations had the same infant mortality rate (5.8 per 1,000 live births).

Causes of mortality vary with age.
Between 2005 and 2009, the leading causes of death in infants under 1 year were congenital anomalies (29%), prematurity (19%) and Sudden Infant Death Syndrome (13%).
Leading causes of death in children ages 1 to 6 were cancer (25.6%), injuries (21.9%) and congenital anomalies.

Birth weights are not changing.
Low birth weight percentages have been similar to the regional, provincial and national trends, and there were no significant differences by geography.
In 2008, high birth weight percentages in Saskatoon Health Region (13.3%) were higher than Canadian rates (12.2%) but lower than Saskatchewan rates (15.1%).
High birth weights were significantly higher in RIS populations (18.3%) compared to non-RIS populations (12.3%).

Breastfeeding initiation is increasing.
The percentage of Health Region mothers who reported having tried breastfeeding, even if it was for a short time, has increased from 83.5% in 2007-2008 to 97.2% in 2009-2010.
Mothers who reported exclusively breastfeeding their last infant for at least six months also increased from 36.5% in 2007-2008 to 47.4% in 2009-2010.

Causes of hospitalization and hospitalization rates change with age, Registered Indian Status and areas of deprivation.
In 2007-2009, infants in Saskatoon Health Region had higher hospitalizations rates than children ages 1 to 3 and 4 to 6.
- The leading causes of hospitalization for infants were conditions arising in the perinatal period (e.g. low birth weight, respiratory distress, pre-term infants).

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iii This rate includes hospitalizations for newborn deliveries
Infants from areas of highest deprivation had significantly higher rates of hospitalizations due to diseases of the respiratory system and conditions originating in the perinatal period than infants from areas of lower deprivation.

In both the 1 to 3 and 4 to 6 age groups, the leading causes of hospitalization were diseases of the respiratory system, followed by injuries and poisoning.

- Diseases of the respiratory system made up 42.3% and 37.7% of hospitalizations among children ages 1 to 3 and 4 to 6 years respectively.
- Injuries made up 10.9% and 18.1% of hospitalizations among children ages 1 to 3 and 4 to 6 respectively. Falls were the leading cause of injury for both age groups (39.8%, and 60.4% respectively).

Hospitalization rates by RIS varied significantly depending on the age group:

- The non-RIS hospitalization rate (1,183.2 per 1,000) for infants was significantly higher than the RIS rate (961.8 per 1,000).
- RIS children ages 1 to 3 had significantly higher rates of hospitalization (69.9 per 1,000) than non-RIS (33.3 per 1,000).
- Hospitalization rates for RIS and non-RIS children ages 4 to 6 were similar (26.1 per 1,000 and 22.1 per 1,000 respectively).

**Emergency department visits higher in areas of highest deprivation.**

- In 2009, the leading cause of emergency department visits in Saskatoon Health Region, for all three age groups, was diseases of the respiratory system (35.1%, 32.6% and 29.3% respectively).

- Rates of emergency department visits decreased as children aged.

- Male children had higher emergency department visitation rates than female children.

- In 2009, the rate of emergency department visits was almost two times higher in children from areas of highest deprivation compared to areas of lowest deprivation (799 vs. 407 emergency visits per 1,000 children).

- The rate of emergency department visits for diseases of the respiratory system in infants was almost three times higher in areas of highest deprivation compared to areas of lowest deprivation (507.0 per 1,000 vs. 182.9 per 1,000 respectively).
- Rates of visits due to diseases of the respiratory system in children ages 1 to 3 were also significantly higher in children from areas of highest deprivation compared to those in areas of lowest deprivation.
- The rate for the leading cause of emergency department visits in children ages 4 to 6 (injury, poisoning and other external causes) was two times higher among children from areas of highest deprivation compared to those in areas of least deprivation.

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iv Includes births.
v 3 year combined rate (2007-2009)
Immunization coverage is increasing.
> Between 2007 and 2011 in Saskatoon Health Region, immunization coverage increased overall.
> Rates for 2-year-old coverage for Measles, Mumps and Rubella (MMR) increased from 70% in 2007 to close to 75% in 2011.
> Rates for 7-year-old coverage for MMR went from 88% in 2007 to 92% in 2011.
> However, there were differences in coverage at the neighbourhood level, and the Health Region is taking steps to address these differences.

Vaccine preventable disease (VPD) fluctuates.
> Hepatitis B and pertussis are two VPDs that are prevalent in the community.
> In Saskatoon Health Region, between 2006 and 2010, the highest rate of routine vaccine preventable disease was for pertussis (24.9 per 100,000).

The percentage of “vulnerable” births is unacceptably high in Saskatoon Health Region, particularly for mothers living in core neighbourhoods of Saskatoon.\textsuperscript{vi}
> In 2010, almost 34% of women in the Health Region delivering a baby, and who completed the In-Hospital Birth Questionnaire (IHBQ), scored 9 or above, signalling cause for concern (for the mother and baby) by those who use and monitor these scores.
> Mothers living in core neighbourhoods (63.6%) were more likely to score 9 or above on IHBQ than those living in affluent and middle-income neighbourhoods (23.6% and 33.5% respectively).
> Mothers of Aboriginal descent were more likely to score 9 or above on IHBQ than mothers of non-Aboriginal descent (70.3% and 27.7% respectively).

Smoking rates are higher among mothers in low-income neighbourhoods.\textsuperscript{vii}
> In 2010, 16.7% of mothers reported smoking at least one cigarette per day. This is about the same as the 16.4% reported in 2006-2007 for women in Saskatchewan.
> Mothers who lived in the core neighbourhoods and mothers of Aboriginal descent both reported significantly higher smoking rates during pregnancy (both above 40%) than other mothers.

Substance use during pregnancy higher among mothers in low-income neighbourhoods.
> In 2010, 5.6% of women living in Saskatoon Health Region who consented to answer the IHBQ reported alcohol and drug use during pregnancy.
> The use of drugs and alcohol during pregnancy was significantly higher in Saskatoon (6.4%) than in rural areas (3.1%).

\textsuperscript{vi} In-Hospital Birth Questionnaire scores greater than 9
\textsuperscript{vii} Based on Canadian Maternity Experiences Survey and asked during the last three months of pregnancy, did the woman smoke daily, occasionally or not at all.
Core neighbourhoods had a higher percentage (16.1%) of alcohol and drug use during pregnancy than both affluent (1.5%) and middle-income neighbourhoods (5.5%).

The greatest difference in substance use was among women of Aboriginal descent (20.5%) compared to women who reported not being of Aboriginal descent (3.1%).

Oral health is worse in low-income neighbourhoods.

While the percentage of Grade One children in Saskatoon Health Region that is cavity-free has remained relatively unchanged over time, children attending schools in low-income neighbourhoods were less likely to be cavity-free (34.1%) than children attending school in other neighbourhoods (59.8%).

Canada is in the midst of a childhood obesity epidemic.

Currently, one in four children and youth in Canada is overweight or obese and rates of obesity are rising. viii
The percentage of young children with healthy weights is declining. Canadian statistics show that among children ages 2 to 5, 15.2% are overweight and 6.3% are obese.²

Children in Grades 5 to 8 from the high-income neighbourhoods in Saskatoon were more likely to watch 2 hours or less of television per day than children from the core or middle-income neighbourhoods (61.3% vs. 44.9% vs. 56.4%, respectively). Children from core neighbourhoods were more likely to watch more than 2 hours per day compared to the high- or middle-income neighbourhoods (55.1% vs. 38.7% vs. 43.6%, respectively).

Of the children who self-identified as Aboriginal, 47.2% reported that they had 2 hours or less screen time per day, compared to 57.5% of non-Aboriginal children. Conversely, 52.8% of Aboriginal children had more than 2 hours of screen time per day, compared to 42.5% of non-Aboriginal children.

The physical environment, both natural and built, plays a significant role in influencing healthy child development.

Some links between children’s environmental exposures and health outcomes are well established (for example, lead and brain impacts, ionizing radiation
and cancer, air pollution and asthma), whereas other links are less well understood.

- There is limited information on the impact of the environment on the health of Saskatoon Health Region children; however, several recent national and international agreements have specifically highlighted the need for assessing the state of children’s environmental health and have called for action to develop children’s environmental health indicators.

**EARLY CHILDHOOD MENTAL HEALTH**

There is very little information available about childhood mental health. However, it is strongly connected to the mental health of family members, particularly mothers.

*Between 2008 and 2011, 12.1% of kindergarteners rated low on the emotional maturity domain of the Early Development Instrument (EDI).*

- The percentage of children with low scores varied greatly among Saskatoon neighbourhoods, ranging from 1.9% to 36.1%.

*Between 2006 and 2009, rates of depression among women during pregnancy (14.1% in early pregnancy and 10.4% in late pregnancy) were consistent with previous research indicating a major depressive disorder can range between 10-19% within this population.*

- Rates were considerably higher among socially high-risk women (29.5%).

*In a study conducted between 2006 and 2009 in the Saskatoon Health Region, the percentage of participants with probable postpartum depression was 8.1%.*

**EARLY CHILDHOOD SOCIAL DEVELOPMENT**

Children's early social environments, particularly the connections they have with their parents, peers and others in the community, are integral to their health and well-being. Because of the lack of availability of data regarding privately funded programs and services, this report focuses on publicly regulated and/or funded programs.

*Approximately 14% of children rated low on the social competence domain of the EDI between 2008 and 2011.*

- The percentage of children with low scores varied greatly among Saskatoon neighbourhoods, ranging from 1.3% to 30.6%.

*In 2011, the number of licensed child care spaces dedicated to children in their early years was limited (6.7 spaces per 100 children aged 0 to 5 in Saskatoon Health Region).*

- There were 8.3 spaces per 100 children in Saskatoon and 2.8 per 100 children in rural Health Region areas.
In 2008, there were 20.3 licensed child care spaces per 100 children ages 0 to 5 in Canada. Saskatchewan had the lowest rate of 9.1 licensed spaces per 100 children ages 0 to 5.

There were 70 prekindergarten programs in 2011-2012 offering a total of 1,120 spaces.

There were 16 rural programs, half of which were in the Saskatoon Rural Planning Zone.

In Saskatoon, 50 out of 54 programs were generally located in areas where there are high numbers of children and higher levels of deprivation.

Full-time kindergarten programs have been shown to be particularly beneficial for students who are lagging behind their peers due to poorer language skills or difficulties in getting along with other children.

In 2011-2012, there were 58 full-time kindergarten programs funded by the Saskatoon Public, Prairie Spirit and Greater Saskatoon Catholic school boards (the province provides funding for half-day kindergarten programs). Fifty-six programs were located in Saskatoon, and two in rural Health Region areas. The programs were cancelled in summer 2012 due to budget shortfalls.

**EARLY CHILDHOOD COGNITIVE DEVELOPMENT**

Cognitive development relates to how children perceive, think and gain understanding of their world. Key components of cognitive development include school readiness and family education levels.

Between 2008-2009 and 2010-2011, successful transition to school (i.e. school readiness) in language and cognitive development, communication and general knowledge varied greatly among Saskatoon neighbourhoods.

In language and cognitive development, the scores ranged from a low of 1.5% to a high of 37.1% of children demonstrating some lack of ‘readiness’ in these areas.

In communication skills and general knowledge, the scores ranged from a low of 3.7% to a high of 36.1% of children demonstrating some lack of “readiness” in these areas.

Educational attainment by parents has important links to children’s health and development.

In 2006, 15.2% of the general Saskatoon Health Region population aged 25 to 64 reported not having a high school certificate, diploma or degree.

Significant differences in educational attainment existed by neighbourhood (ranging from 5.9% to 49.0% of the population ages 25 to 64 not having a certificate, diploma or degree).
EARLY CHILDHOOD MATERIAL WELL-BEING

The material well-being of children and their families integrates information on child and family poverty with related measures, such as food security and housing affordability.

A significant number of children under six live in poverty.

> In 2006, 23.3% of children less than six years of age in Saskatoon Health Region lived below the before-tax low-income cut-off (LICO-BT). In Saskatoon, more than one in four children less than six years of age lived in low-income households (27.4%, or 3,758 children).

> Poverty rates varied by Saskatoon neighbourhoods, ranging from 5.0% to 82.9% of children less than six years of age living below the before-tax low-income cut-off (LICO-BT).

> The number of children living in poverty in rural areas (one in eight) was half the rate for the city of Saskatoon (12.9%, or 693 children).

> After accounting for the effects of income redistribution in the tax and transfer systems, 17.5% of children less than six years of age in Saskatoon Health Region lived below the low-income cut-off after tax (LICO-AT).

> In the Health Region’s rural communities, 9.5% (514) lived below the low-income line (LICO-AT).

> Large differences in child poverty prevalence by neighbourhood exist, ranging from 5% to as high as 64.5% (LICO-AT).

Approximately 1 in 4 households in the Health Region spent 30% of more of their income on housing costs in 2010.

> Similar to percentages in 2006, estimates for 2010 found that approximately one quarter of Saskatoon households spent 30% or more of their income on housing costs.

> More renters in Saskatoon had housing affordability problems than homeowners (44.8% versus 15.0%).

> Vast differences in housing affordability were seen at the neighbourhood level, ranging from 6.4% to 50.8% of households spending 30% or more of their income on housing costs.

> The 2006 Census found that a greater percentage of rural homeowners (14.7%) in Saskatoon Health Region had challenges with housing affordability compared to city homeowners (10.9%), despite lower rural housing costs.

ix These data are reported for children ages 0 to 5 inclusive and are described in the language used by the data provider. Most other indicators in this report are reported for children ages 0 to 6 inclusive.
In 2012, Saskatchewan had the second highest number of families with children using food banks in Canada. A breakdown of the Saskatoon Food Bank’s clients indicated that:

- Saskatchewan has one of the highest numbers of families with children using food banks in Canada, second only to Manitoba.
- In 2007-2008, almost one in ten Saskatchewan households with children ages 0 to 5 reported that they experienced moderate to severe food insecurity over the past year.
- About 4 in 10 food bank users in Saskatoon were children below age 17 and 15% were below age 6.
- Over half of all families using the Saskatoon Food Bank were single-parent families.
The following recommendations are designed to improve the health and development of children ages 0 to 6, their families and communities in Saskatoon Health Region. They are respectfully directed to the Saskatoon Regional Health Authority (SRHA) and the Saskatoon Regional Intersectoral Committee (SRIC). Significant intersectoral action is needed to improve child health and development and also requires a combination of strong provincial and local leadership and action.

The recommendations focus on prevention and health promotion and encourage collective action from an array of stakeholders, including government and businesses. Models for parental education support, for example, cannot be addressed by any one sector and should be considered in all government policies and goals.³

A focus on prevention, health promotion and reduced health inequity in the early years will help reduce the social and economic burden of illness, not only in childhood but also throughout the adult years. This focus could be the single most important strategic investment that we as a society could make to ensure a prosperous future. Most importantly, it is the right thing to do.

DEVELOP AND IMPLEMENT A PROVINCIAL EARLY CHILDHOOD HEALTH AND DEVELOPMENT STRATEGY

Policy plays an important role in influencing developmental health outcomes. The four pillars of a province-wide, cross-ministerial and regional intersectoral strategy should include:

1. Agreement on a key goal – “18 by 18”

30% of children ages 0 to 6 in our Health Region are vulnerable in at least one developmental area - those areas being physical health and well-being, social competency, emotional maturity, language and cognitive development, and communication skills.³

We recommend the adoption of a shared commitment to work together to reduce this score to 18% by 2018.
2. A focus on family needs

Families require good supports to ensure the best possible start for their children. We need to take a strategic approach and include the development of provincial policies and initiatives that consider the needs of all families, with special emphasis on newcomer, single-parent, First Nations, and Métis families, to reduce health inequities. Provincial cross-ministry and regional cross-sector roles will be required. The following should be considered:

> Parental benefits for all in the first year of a child’s life (including arrival within a family as with adoption) with a minimum income for healthy living;

> High quality, affordable, accessible and developmentally appropriate early learning and child care services for all, including expanded child care, preschool and prekindergarten programs, to meet families’ needs and preferences for their children before they start school; and

> Expanded, locally led, evidence-based parenting supports that are integrated across sectors and provide evidence-based education about parenting skills and styles.

3. A holistic approach for improving the health and development of First Nations and Métis children

Chapter 1 has provided a clear link between the health of First Nations and Métis peoples and the range of influences, including social determinants and historical complexities. While all of the recommendations in this chapter apply equally to all people of the Saskatoon Health Region, the complexity of First Nations and Métis health issues requires further attention and action. As such, the following should be considered:

> Creating better awareness of the historical and social contexts of First Nations and Métis peoples;

> Providing more training to increase cultural competency and safety for professionals across sectors;

> Employing advocates and cultural translators to bridge understanding between systems and First Nations and Métis families and provide system navigation support;

> Conducting further intervention research aimed at improving the lives of First Nations and Métis children through collaborative, respectful and equitable partnerships;

> Increasing delivery of services by First Nations and Metis agencies and providers to children and families; and

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xi These recommendations are based on the Canadian Family Policy Assessment Tool indicator framework [NCCHPP, June 2012 www.kidskan.ca/policyassessment], developed by SPHERU and HELP, based on similar international work.

xii Given the local demographic context of the Saskatoon Health Region, these recommendations refer to First Nations and Métis peoples. Nationally, however, the term Aboriginal is used to refer to all of Canada’s first peoples, including First Nations, Métis and Inuit peoples.
> Focusing on the needs of children first in matters of jurisdicational dispute over funding health care services for First Nations children by supporting a long-term implementation plan of Jordan’s Principle.⁶

4. Commitment to targeted investments

“Research shows that public investment in the policies that promote early developmental health not only helps children and families directly but provides benefits across society. Canada lags behind other industrialized countries in these investments, which has health and well-being consequences for all Canadians (...) the reality of parenting today requires new public policy responses that promote quality home and community based environments.”⁷

In order to support family needs, a provincial early years strategy should include:

- **Targeted investments to reduce poverty** and ensure food and housing security for children;
- Plans to **increase the proportion of resources allocated to early years** and ensure expenditure is allocated progressively across the social gradient (e.g. increased wages for early years workers, more child care spaces and subsidized child care for those most in need);
- Recognition of the **growing and changing demographic profile** of the early years population in any new funding models; and
- Appropriately **funded efforts aimed at improving cultural competency** (named in various recommendations within this report).

5. Robust monitoring tools

The challenges in finding data to inform this report point to the importance of ensuring that robust monitoring tools are in place to provide better information about how well our children are doing and to monitor the impact of investments made. In addition, there has been work initiated to examine potential evidence-based policy options to consider at the provincial level.⁸ As such, monitoring and reporting efforts should include:

> A review of existing gaps in early years surveillance, along with improvements, to ensure that relevant, reliable provincial and local indicators are available and are consistently collected, monitored and reported. Particular consideration should be given to resolving data gaps for First Nations, Métis, newcomer and immigrant populations;
> Routine reports on a core set of health equity indicators for child health status and determinants of health, available at a neighbourhood level and by rural planning zones;
> Regular policy monitoring to seek new options and track the impacts of policies over time; and
> Resources to support ongoing applied research and knowledge exchange to improve maternal and child health monitoring and outcomes (e.g. linking
the In-Hospital Birth Questionnaire and the Early Development Instrument to better understand how risks at birth potentially result in poorer childhood development outcomes).

ENCOURAGE AND SUPPORT HEALTH SECTOR ACTION

1. Deliver family-centred, accessible, integrated services

Feedback from clients/patients, families and service providers signals that more work is needed to bridge gaps and ensure seamless delivery of health services across the Region. As such:

> The Health Region’s value stream for maternal and child services and the creation of the new Saskatchewan Children’s Hospital provide opportunities to improve system coordination and integration and should include programs and services that span Population and Public Health, Primary Health, Acute Medicine and Complex Care, Maternal and Child Services, Mental Health and Addictions, and Cancer Care, to name a few.

> The various needs of the population should be addressed in reviewing the availability and accessibility of Health Region programs and services for children. For example, children and families living in urban and rural areas as well as areas of highest deprivation, First Nations, Métis, and newcomer families and children may have varying needs.

> The Region should enhance its current efforts within the health system towards improving First Nations and Métis health. These include:
  
  • Continued implementation of the Aboriginal Health Strategy;
  
  • With the Saskatoon Tribal Council and Saskatoon Regional Health Authority Memorandum of Understanding (MOU) signed in September 2012 as an example of setting future direction in partnership, the development, incorporation and implementation of Memorandums of Understanding between the Saskatoon Regional Health Authority and First Nations and Métis should be continued;
  
  • Increasing the proportion of First Nations and Métis employees in the Health Region through programs such as Step into Health Careers;
  
  • Shifting from an illness-driven biomedical approach to a holistic wellness approach that focuses on strengths and preventive medicine;
  
  • Acceptance of traditional knowledge as credible and authentically integrating client beliefs into future individual health planning;
  
  • Continued efforts towards a coordinated team-based approach to care that includes physical, mental, emotional, social and spiritual support, providing consistent and familiar case management to families;

* * *

A Value Stream is defined as “[a]ll activities, both value and non-value added, that contribute to the overall patient experience” in Introduction to Hoshin Kanri (Strategy Deployment): Meeting in a Box, Saskatoon Health Region, 2012.
• Pending a successful evaluation, establishing and expanding the First Nations and Métis Health Services pilot to Maternal and Child Health Services; and
• Assessing current organizational and department cultural competency and following up with targeted improvement initiatives.

2. Bolster health promotion and protection, illness and injury prevention efforts

Continued focus on efforts upstream is important in order to achieve provincial targets. Suggested actions include:

> Continued focussed effort to ensure appropriate primary health care is provided to all residents of Saskatoon Health Region with emphasis on ensuring equitable care to those in most need (e.g. children in areas of highest deprivation).

> Aligning efforts with the provincial strategy on achieving healthy weights and reducing obesity. At a healthy public policy level, greater emphasis on food security and nutrition, physical activity and the built environment, including human transportation and city planning, are essential.

> Making mental health a priority by:
  • Recognizing that scientists and practitioners call for prevention and early intervention to best address mental health issues before they become deeply entrenched.
  • Actively raising awareness and promoting positive mental health in the community with the aim to improve mental health and de-stigmatize mental illness;
  • Fostering mother-child and parent-child attachment at an early onset;
  • Building supportive environments so that families dealing with mental health issues get, and sustain, the treatment that they need; and
  • Streamlining mental health service delivery across sectors to better serve the community.

> Working with key community partners to achieve provincial immunization targets so that 95% of children are up to date on publicly funded vaccines by ages 2 and 7 by March 2017.

> Aligning with the provincial children’s oral health strategy to improve oral health outcomes for ages 0 to 6 by implementing a comprehensive approach to prevention and treatment. At a regional level this could also include promotion of a universal dental care program and improving water fluoridation to optimal levels in all Health Region communities.

> Maintaining high levels of breastfeeding initiation and supporting sustained, exclusive breastfeeding rates by emphasizing supportive environments and examining barriers to breastfeeding.
> Participating in the development of a provincial comprehensive injury prevention strategy and, in turn, developing an injury prevention program in the Health Region.
>
> Developing comprehensive service frameworks for individuals who have Fetal Alcohol Spectrum Disorder (FASD) and establishing an FASD prevention strategy.

3. Work with partners to better protect children from environmental health risks

Strategies should include:

> Measurement of success by means of setting regional priorities for surveillance, reporting and research to improve understanding of the environmental risks to children, along with regular publications to enable evaluation of effectiveness;
>
> Advocacy for evidence-based environmental policies and regulations that are inherently protective of child health;
>
> Education and communication to raise awareness about environmental hazards and promote action that can be taken to minimize childhood health risks; and
>
> Consideration of the other determinants of health such as socio-economic status and culture that may have significant influence on the susceptibility of children to environmental exposure.

References


Authors


Contact the Public Health Observatory

(306) 655-4679
pho@saskatoonhealthregion.ca
www.saskatoonhealthregion.ca/PHO