



# Child and Youth Report

# Rapport sur les enfants et les jeunes



**Healthy Child Manitoba**  
**Enfants en santé Manitoba**

**Rapport sur les enfants et les jeunes 2017 Child and Youth Report**

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## A Message from Manitoba's Healthy Child Committee of Cabinet

In December 2007, the Legislative Assembly of Manitoba proclaimed its long-time commitment to children and youth in the *Healthy Child Manitoba Act*. This statute enshrines our province's long-term, whole-of-government partnership with communities to improve outcomes from pre-birth to adulthood through the Healthy Child Manitoba Strategy of prevention and early intervention.

This report on the status of Manitoba's Children and Youth is a major public report legislated in the Act. The report provides the beginnings of an ongoing story and, we hope, an ongoing public dialogue about what matters most to Manitobans: How are Manitoba's children and youth doing? The *Healthy Child Manitoba Act* sets out four goals for the strategy: that, to their fullest potential, all of Manitoba's children and youth (prenatal to 18 years) will be (i) physically and emotionally healthy; (ii) safe and secure; (iii) successful at learning; and (iv) socially engaged and responsible. The report is organized by these four goals, with chapters following the growing phases from prenatal, to early childhood, to middle childhood, to adolescence.

As with every comprehensive report, this one tells a story with both successes and challenges, areas to celebrate and areas to keep working on. We invite you to read this report and tell us what you think and how much it *matters* to you. The future of every one of us depends on what we do collectively for our youngest citizens now. Safe communities, economic prosperity, stewardship of our environment, peace, belonging, identity, and mutual respect all grow from nurturing environments, right from the start. Our children's futures will be shaped, for better or worse, by our choices today. Will they be healthy, safe, lifelong learners, responsible to themselves and others? It is up to all of us.

Our fervent hope is that we will continue to choose to be champions for all of our children. They do not vote (yet), but we can vote for them and be devoted to them, in our daily lives and in the decisions we make in our homes, in our communities, in our legislature. As adults, together with our youth, we can create better places and spaces, opportunities and experiences, for our children to flourish. We can learn from data about how they are doing so that they can do better, live better, and be better.

Thank you for your commitment to the children and youth of Manitoba.

### **Honourable Ian Wishart**

Chair, Healthy Child Committee of Cabinet (HCCC)  
Minister of Education and Training

### **Honourable Eileen Clarke**

Minister of Indigenous and Northern Relations

### **Honourable Scott Fielding**

Minister of Families

### **Honourable Kelvin Goertzen**

Minister of Health, Seniors and Active Living

### **Honourable Rochelle Squires**

Minister of Sustainable Development, Minister responsible for the Status of Women, and Minister responsible for Francophone Affairs

### **Honourable Heather Stefanson**

Minister of Justice and Attorney General

## Message du Comité ministériel pour Enfants en santé Manitoba

En décembre 2007, l'Assemblée législative du Manitoba a adopté la *Loi sur la stratégie « Enfants en santé Manitoba »*, qui consacrait son engagement à long terme envers les enfants et les jeunes. Cette loi prévoit un partenariat à long terme entre le gouvernement provincial dans son ensemble et les collectivités en vue d'améliorer la vie des enfants, de la période prénatale jusqu'à l'âge adulte, par l'intermédiaire de la stratégie de prévention et d'intervention précoce Enfants en santé Manitoba.

Le présent rapport sur les enfants et les jeunes du Manitoba est un rapport public de grande importance prévu par la *Loi sur la stratégie « Enfants en santé Manitoba »*. Il représente le début d'une histoire qui se poursuit et, nous l'espérons, d'un dialogue public continu sur ce qui tient le plus à coeur à la population manitobaine : la situation des enfants et des jeunes au Manitoba. Conformément à la *Loi sur la stratégie « Enfants en santé Manitoba »*, cette stratégie a quatre objectifs : faire en sorte que tous les enfants et les jeunes du Manitoba, dans la pleine mesure de leurs possibilités, soient en bonne santé physique et affective, soient en sécurité, réussissent à apprendre et soient engagés et responsables dans le domaine social (de la période prénatale à l'âge de 18 ans). Le rapport est organisé en fonction de ces quatre objectifs et ses chapitres suivent l'évolution des enfants, de la période prénatale à la jeune enfance, puis à la période intermédiaire de l'enfance et à l'adolescence.

Comme tous les rapports exhaustifs, ce rapport décrit aussi bien les succès que les difficultés, les aspects à célébrer que les aspects à améliorer. Nous vous invitons à le lire et à nous dire ce que vous en pensez et quelle importance tout ceci a pour vous. Notre avenir à tous dépend de ce que nous faisons ensemble actuellement pour nos plus jeunes concitoyens. C'est lorsque le milieu est encourageant que, dès le départ, les collectivités sont sûres, l'économie prospère et l'environnement bien géré, que la paix règne et que se crée un sentiment d'appartenance, d'identité et de respect mutuel. Pour le meilleur ou pour le pire, l'avenir de nos enfants sera façonné par les choix que nous faisons aujourd'hui. Seront-ils en santé et en sécurité, deviendront-ils des apprenants à vie et des personnes responsables vis-à-vis d'elles-mêmes et des autres? Cela dépend de nous tous.

Nous espérons sincèrement que nous continuerons à nous battre pour tous les enfants. Ils n'ont pas encore le droit de vote, mais nous pouvons voter pour eux et nous consacrer à eux, dans nos vies quotidiennes et dans les décisions que nous prenons à la maison, dans la communauté et à l'Assemblée législative. Avec l'aide de nos jeunes, nous pouvons, nous les adultes, améliorer le milieu, les possibilités et les expériences afin que nos enfants prospèrent. Nous pouvons étudier les données sur leur situation, afin qu'ils puissent mieux faire, mieux vivre et mieux être.

Nous vous remercions de votre engagement à l'égard des enfants et des jeunes du Manitoba.

**Monsieur Ian Wishart**

Président du Comité ministériel pour Enfants en santé Manitoba  
Ministre de l'Éducation et de la Formation

**Madame Eileen Clarke**

Ministre des Relations avec les Autochtones et le Nord

**Monsieur Scott Fielding**

Ministre des Familles

**Monsieur Kelvin Goertzen**

Ministre de la Santé, des Aînés et de la Vie active

**Madame Rochelle Squires**

Ministre du Développement durable, Ministre responsable de la Condition féminine et des Affaires francophones

**Madame Heather Stefanson**

Ministre de la Justice et procureure générale

## Executive Summary

Health is more than the absence of disease – it is an evolving human resource that helps children, youth, and adults adapt to the challenges of everyday life, injuries, cope with adversity, feel a sense of personal well-being, and interact with their surroundings in a way that promote successful development...children’s health is a nation’s wealth, as a sound body and mind enhance the capacity of children to develop a wide range of competencies that are necessary to become contributing members of a successful society.” Source: Center on the Developing Child at Harvard University. (2010). The foundations of lifelong well-being are built in early childhood. <http://www.developingchild.harvard.edu>

### 1.1 Introduction

The health and well-being of children and youth in Manitoba is largely determined by early development. We all have a role to reduce risks and enhance protective factors in Manitoba’s children, families and communities. Strong evidence shows that investments in the well-being of children yield a significant financial return.

In March 2016, Manitoba passed *The Path to Reconciliation Act* to advance reconciliation in Manitoba. The Act requires Manitoba to develop a reconciliation strategy that builds on meaningful engagement with Indigenous nations and people and all Manitobans.

This is the second legislated public report on the status of Manitoba’s children and youth, required every 5 years, under the *Healthy Child Manitoba Act*. The report is organized by four stages of child and youth development (prenatal, early childhood, middle childhood, youth), along with the four outcome goals of the Healthy Child Manitoba Strategy (physical and emotional health, safety and security, success at learning, social engagement and responsibility).

Each chapter discusses key indicators in each stage for each outcome. Where possible, trends over time, and comparisons with Canada, and by gender, socioeconomic status, region, and ethnicity are included. The purpose of the report is to provide descriptive data to inform Manitobans about progress over time and priorities for the future.

### Chapter 2 – Who are Manitoba’s Children and Youth?

- Children and youth (ages 0-19 years) represent a quarter of Manitoba’s population (25.3%, over 335,000), proportionally more than Canada (22%). Over the past decade, the number of children ages 0-4 years has increased by 21%.
- Over half of children and youth in Manitoba (56%) live in urban settings.
- Since 2000, most Manitoba children and youth (76%) live in two-parent families. Proportionally more live in single parent families (24%), compared to Canada (21%).
- Our province’s young people are diverse in culture, ethnicity, identity, and language.
  - More than one in four (29%) (90,000 children ages 0-19) are Indigenous (First Nation, Metis and Inuit), almost four times higher than Canada, and growing over time. Thirty

per cent of Manitoba's children ages 0-5 are Indigenous compared to only 8% in Canada overall.

- Since 2012, the number of newcomer children and youth, born in other countries, who made Manitoba their permanent home has grown by 33%. A larger proportion of Manitoba's newcomers are younger, compared to Canada.
- The most commonly spoken non-official languages in Manitoba are Tagalog (Filipino), German, Punjabi, Cree, Ojibway, Spanish, and Mandarin.
- One in five Manitoba young people are from a visible minority group.
- Since 2001, the number of children in care has grown, from 1.9% to 3.5% of all children; this group is predominantly Indigenous.
- Socioeconomic status is an important factor in child development. Early childhood socioeconomic status can be an important predictor of brain development, learning, behaviour and other health outcomes. Children living in lower socioeconomic circumstances are more likely to have adverse childhood experiences and to encounter harmful levels of stress.
- Children in specific demographic segments are more likely to experience poverty than the general population. Acute rates of child poverty exist among lone-parent families and Indigenous families, notably among First Nation families living on reserve where child poverty rate is extremely high. Poverty presents challenges in accessing nutritious food as well as adequate, suitable and affordable housing, contributing to the risk of negatively influencing the health outcomes of children.
  - Adequate housing is considered a basic prerequisite for good health. This is particularly true for young children.
  - Food insecurity is the term used to describe hunger in rich countries, and it is an important determinant of child health outcomes, including chronic conditions and mental health problems.
  - Higher levels of parent educational attainment are strongly associated with positive outcomes for children in many areas of development including school readiness, educational achievement, health and prosocial activities.
- Child poverty in Manitoba ranges from 12% to 22%, depending on the measure, and is higher than Canada.
  - Children living in female-led lone-parent families are up to four times more likely to live in poverty, children living in compared to couple families.
  - One in two First Nations children, one in four Metis, one in four Inuit, and one in six non-Indigenous children in Manitoba live in poverty, all higher than in Canada overall.
- Fewer Manitoba parents have completed secondary or post-secondary education (47%), compared to Canada (56%).
- Fewer Manitoba families live in urban core housing (10-11%), compared to Canada (13%). Indigenous children are more likely to live in housing in major need of repair.
- Food insecurity is higher for children in Manitoba (11% in 2012), compared to Canada (10% in 2012).

### Chapter 3 - Prenatal

The health and well-being of expectant parents influences the health, well-being and development of their unborn children. There are many influences: social and demographic factors, social and physical environments, relationships and supports, and environmental exposures. These influences can be significant and long term. The social and emotional health of the parents and the family are important determinants of their own well-being and the health of their newborns. Supportive families and communities may mitigate the risk of adverse issues.

- Socioeconomic status is an important factor influencing healthy pregnancies and healthy babies. Higher levels of income and education among parents are associated with better outcomes.
- A mother's nutrition during pregnancy influences her own health and facilitates the healthy development of the fetus. Alcohol, tobacco and other drug use during pregnancy can have adverse outcomes for the infant, developing child and beyond into adulthood.
- When women have mental health problems during pregnancy their children are at increased risk of having mental health and development problems.
- Most Manitoba mothers (78%) give birth in young adulthood (ages 20-34), similar to across Canada. Manitoba has a larger proportion of younger mothers (ages 15-19), while Canada has a larger proportion of older mothers (age 35+).
- Teen pregnancy and birth rates continue to decline over time in Manitoba and remain higher in northern Manitoba and lower in southern Manitoba.
- Fewer babies (off-reserve) are being born into socioeconomic hardship over time. For instance, more mothers have a high school education (85% in 2015 compared to 78% in 2003) and family's financial difficulties decreased from 18% in 2003 to 14% in 2015.
- However, fewer women in inner city Winnipeg and northern Manitoba, where needs are greater, are accessing prenatal care over time.
- Alcohol use, smoking, and relationship distress during pregnancy are all declining over time in Manitoba. However, maternal depression and/or anxiety are on the rise.
  - Alcohol use decreased from 14% in 2003 to 10% in 2015
  - Smoking during pregnancy decreased from 21% in 2003 to 13% in 2015
  - Relationship distress decreased from 6% in 2003 to 4 in 2015%
  - Depression and anxiety increased from 13% in 2003 to 18% in 2015
- Fetal alcohol spectrum disorder (FASD) is referred to as an "invisible disability" because the majority of people with FASD do not have the associated facial features.
- Whether or not alcohol exposure leads to FASD depends on a set of biological and social factors that interact in different ways for each person. Biological factors can include a woman's sensitivity to alcohol, metabolism, and size. Social factors like chronic stress, violence, trauma, or poverty can increase the chances that a baby might be born with FASD.

## Chapter 4 – Early Years (Birth to Age 5 Years)

The first five years of life are a significant and sensitive period that can profoundly affect the future of a child. In early childhood, brain development is very responsive to all experiences, both positive and negative. Healthy social, emotional, and physical environments in the home and broader community are important for healthy child development.

- Manitoba's preterm birth and low birth weight rates are relatively stable and similar to Canada.
- Manitoba has a larger proportion of babies born large-for-gestational age than Canada, but the rate appears to be declining faster over time in Manitoba.
- Breastfeeding initiation and exclusive breastfeeding have increased over time in Manitoba and are now both higher than in Canada.
  - Breastfeeding initiation increased from 84% in 2007-2008 to 93% in 2011-2012
  - Exclusive breastfeeding for at least six months increased from 25% in 2007-2008 to 31% in 2011-2012. The Canadian rate was 26% in 2011-2012.
- Pediatric dental extractions and surgeries (under age 6 years) have both declined over the last decade.
  - The rate of dental extractions among children under six was 18 per 1,000 in 2006/07, and 11 per 1,000 in 2015/16
- Immunization rates among children at age two are relatively stable, but still lower in children in families living in lower-income, First Nations families, or families led by teen-aged mothers.
- Over the past decade, the early physical health and well-being, and emotional maturity, of Manitoba's Kindergarten children has been stable, at levels similar to Canada.
- Infant (under age 1) injury hospitalization rates appear to be increasing, while preschool (age 1-4) rates appear to be decreasing, with falls as the number one cause.
- Infant mortality continues to be higher in Manitoba than in the rest of Canada, particularly in northern Manitoba.
  - Between 2010/11 and 2014/15, Manitoba's overall crude infant mortality rate was 5.9 per 1,000 live births. This varied by region – the highest rate being in the Northern Region (10.9) and the Southern Region had the lowest rate (4.8).
- One in three Manitoba children under age 6 lives in poverty (1.7 times higher than Canada rate), and one in eight lives with food insecurity, also higher than Canada.
- In 2016/17, 1,371 children and youth under 18 accessed an emergency family violence shelter funded by the Manitoba Government. That number fluctuated slightly over the five preceding years.
- More children under age 6 have access to licensed early learning and child care. Approximately three in four preschoolers do not.
- Over the past decade, the early language and cognitive development (early literacy and numeracy) of Manitoba's Kindergarten children has been stable at a provincial level, but with significant variation across communities.



- Children’s overall readiness to start school in Kindergarten has remained stable over time, with more than one in four children not ready in at least one area of early development (e.g., physical, social, emotional, cognitive and general knowledge).

### **Chapter 5 - Middle Childhood (Ages 6 to 14 Years / Grades 1 to 8)**

Middle childhood is a period in which significant developmental milestones are achieved. For children ages 6 to 14, developmental tasks and stages include increasing physical, emotional, learning, and social abilities and capacities. Physically, children continue to develop rapidly, Children’s brains are also developing in middle childhood. With these changes comes the ability to engage with and explore the world in new and more sophisticated ways. Puberty begins toward the end of the middle years, from around 11 to 14.

- Asthma remains the most common chronic disease in middle childhood and appears to be increasing over time. It is two to three times more prevalent for First Nations and Metis children.
  - In 2013/14, the asthma rates were 9% for boys and 11% for girls in Manitoba, compared to 13% for boys and 9% for girls in Canada.
- The prevalence of attention deficit hyperactivity disorder (ADHD) is increasing over time, as is Autism Spectrum Disorder (ASD).
  - For ages 6 to 12, the prevalence of ADHD was 7.5% in 2005/06-2008/09 and 8.7% in 2009/10-2012/13.
  - For ages 6-12, the lifetime diagnostic prevalence of ASD was 1.2% in 2005-/06-2008/09 and 1.5% in 2009/10-2012/13.
- Diagnosing Fetal Alcohol Spectrum Disorder (FASD) has great benefits for children at any stage in their development. Commonly used parenting and education techniques may not work for children with FASD and can result in frustration for both the child and the adult. By having clear information about the disability, parents, teachers, and other professionals can provide appropriate interventions and advocate for effective supports for the child. Shifting from the perspective of “trying harder” to “trying differently” can help parents and those working with children living with FASD look for ways to assist children to successfully learn, grow and adapt. (<http://fasdmanitoba.com/assessment>).
- Approximately two-thirds of Manitoba 7-year-olds have had all of the recommended immunizations. The Northern Health Regions had the highest rate at 74%.
- Two-thirds of Manitoba Grade 7 and 8 students have healthy weights. Other data indicate overweight and obesity have risen over time to 26% for Manitoba children (ages 12-19), higher than Canada.
  - Only half of Manitoba Grade 7 and 8 students are active for the recommended 60 minutes per day, with one in six being inactive daily.
  - 15% of Grade 7 and 8 students are inactive.
- Less than 40% of Grade 7 and 8 students get the recommended 9 hours of sleep each school night.
- Many students spend 3 or more hours of screen time each weekday (40%) and on weekends (60%).
- Less than half of Grade 7 and 8 students get the recommended amount of fruits and vegetables daily.

- Over one-third of Grade 7 and 8 children are at risk for future mental health problems. Further, 31% of boys and 43% of girls reported that they had felt so sad or hopeless in the past year that they stopped doing their usual activities for a while.
  - Diagnosed anxiety and mood disorders, and conduct disorder, (ages 6-12 years) appear to be on the rise, particularly in lower-income communities.
    - The four-year diagnosed prevalence of mood and anxiety disorders among 6- to 12-year-olds was 1.8% in 2005/06-2008/09 and 2.2% in 2009/10-2012/13.
    - The four-year diagnostic prevalence of conduct disorders among 6- to 12-year-olds was 1.9% in 2005/06-2008/09 and 2.1% in 2009/10-2012/13.
  - One in five Grade 5 children report at least one mental health difficulty.
- Unintentional injury hospitalizations in middle childhood appear to be declining over time, with falls as the leading cause (similar to early childhood).
  - The rate of injury hospitalization among children aged 5-9 was 1.4 per 1,000 population in 2015/16.
  - Motor vehicle collisions continue to be the leading cause of death due to unintentional injury.
- Police-reported family violence among children and youth (ages 0-17 years) is higher in Manitoba, than in Canada. The rate is higher among girls than it is among boys.
  - In 2015, the rate of police-reported family violence among children and youth 0 to 17 years of age was 374 per 100,000 in Manitoba.
- Up to a third of Grade 4-6 students report being bullied (verbal, social, physical, cyber). The rate is similar for Grade 7-8 students (ridicule, body shaming, physical threat or injury, racism).
- Children's (under age 12) exposure to household second-hand smoke has dropped over the past decade.
- Almost half (42%) of all children and youth ages 0 to 18 years who are living in social housing are 6-12 years.
  - More Manitoba children under age 15 live in core housing need (16%), compared to Canada (14%). Children in lone-parent families are 4 times more likely to live in core housing need compared to children living in couple families.
- Food insecurity for children ages 6-17 appears to be declining in Manitoba but is still higher than Canada.
  - In middle childhood (ages 6-14), more First Nations and Metis children in Manitoba live in households that have low or very low food security, compared to Canada.
  - In Manitoba in 2011/12, 10% of children ages 6-17 lived in households that had moderate or severe food insecurity.
  - Manitoba 2012: 26% of First Nation households with children ages 6-14 had low or very low food security, as did 20% of Metis households with children ages 6-14.
- Performance in middle years academic assessments have increased for the most part among Manitoba students.
  - However, less than half of students meet expectations in all areas of Grade 3 numeracy and Grade 7 mathematics, and as low as one in six Indigenous students meet these expectations.

- Between roughly 40-60% of students meet expectations in all areas of Grade 3/4 reading and Grade 8 reading comprehension, and as low as one in six Indigenous students meet these expectations.
- The number of children who are homeschooled in Manitoba has almost quadrupled (3.7x) since 2002.
- In Manitoba, 70% of First Nations children and 40% of Metis children (ages 6-14) thought it was somewhat or very important to speak an Indigenous language.
  - The number of Manitoba students enrolled in public school Indigenous language programs increased by 23% between 2001/02 and 2014/15.
- Most 12- to 14-year-olds in Manitoba feel a sense of belonging to their local communities.
- Most (80%) of Manitoba's Grade 5 students are prosocial (e.g., considerate of others' feelings, share, help, are kind to others).
- Between 40%-60% of Grade 7 students are competently engaged in school learning, based on teacher assessments.
- Based on youth self-report in Grades 7 and 8, more than 80% of students feel they belong and are safe at school, and that the adults at school care about them and can be trusted.
  - 91% feel they belong and are safe at school
  - 90% feel they are a part of the school
  - 87% are happy to be the school
  - 85% feel close to the people at their school
- Three in four Grade 7 and 8 students would talk to a counsellor or other adult if they needed help.
- One in six (15%) of Manitoba's Grade 5 students have some or significant peer relationship problems (e.g., not having at least one good friend, being picked on).

### **Chapter 6 - Youth (Ages 13 to 19 Years / Grades 7 to 12)**

Youth is an important time of transition and transformation, when roles, relationships, and expectations change. Youth are expected to become more independent and responsible, while undergoing dramatic physical and emotional changes, with increased societal and peer pressure. Youth is also a time of exploration, where experiences and behaviours can have long-term effects that last into adulthood.

- In Manitoba, about two-thirds (63%) of youth (ages 15-19) self-rate their health as excellent or very good, lower than Canada (70%). More females (64%) than males (61%) reported their health as excellent or very good.
- Manitoba has one of the highest rates of Type 2 diabetes in children in the world, 12 times higher than any other province in Canada.
- The prevalence of attention deficit hyperactivity disorder (ADHD) in youth (ages 13-19) is on the rise. In the four-year time period 2009/10-2012/13 the prevalence was 4.8%. The prevalence is more than twice as high among boys compared to girls.
- The prevalence of Autism Spectrum Disorder (ASD) and other developmental disorders in youth (ages 13-19) is also on the rise. In 2009/10-2012/13 the ASD prevalence rate was 1.2%.
- Almost three-quarters of Manitoba 12- to 19-year-olds are physically active during their leisure time, similar to Canada.

- As Manitoba youth get older, they are less likely to meet the recommended 60 minutes of daily physical activity, decreasing from 51% of Grade 7 students to 39% of Grade 12 students, and girls are less physically active than boys at each grade.
- For Manitoba youth ages 12-24 years, physical activity varies between Indigenous groups: 62% of First Nations youth were moderately active or active (in the combined years 2011 to 2014). As were 66% of Metis youth, and 70% of non-Indigenous youth.
- Over half (54%) of Grade 9-12 students in Manitoba spend 3+ hours daily on screen time during the week, rising to two-thirds (67%) on weekends. Older students spend more screen time than do younger students.
- Overweight and obesity are on the rise. Two-thirds of boys and three-quarters of girls in Grades 9-12 have healthy weights.
- Only 14% of Manitoba Grade 9-12 students get the recommended 9 hours of sleep on school nights.
- Three percent of Manitoba Grade 7-12 students self-identify as being transgender and 5% have questioned their gender identity. Five percent of students reported being attracted to both males and females, and 2% reported being attracted to members of the same sex.
- Three-quarters (74%) of Manitoba Grade 7-12 students report that they have not had sex. This decreases as age increases: 96% in Grade 7 to 51% in Grade 12.
  - The most common age reported as the first time having sex was age 15 years (24%).
  - The most commonly used contraceptive was condoms (81%), while 13% reported not using any method of protection.
  - Of students reporting having sex, 17% reported having sex when they did not want to do so.
  - While half (51%) of the students were comfortable discussing contraception with their partners, over a third (37%) reported having unplanned sex after using alcohol or drugs during the past year.
  - Manitoba youth (ages 15-19) continue to have high rates of sexually transmitted infections (STIs). Between 2012 and 2016, the most commonly reported STIs were chlamydia and gonorrhea. The rate of chlamydia among Manitoba youth ages 15 to 19 was 1,947 per 100,000 population in 2016. The rate had declined from 2012 to 2014, and then increased again in 2016. The rate of gonorrhea among Manitoba youth ages 15 to 19 was 539 per 100,000 population in 2016. That was up 35% from 2012, when it was 398 per 100,000 population.
- Three in four (74%) Manitoba youth (ages 15-17) self-report their mental health as excellent or very good, declining to two-thirds (62%) for young men at ages 18-19, but stable (75%) for young women.
  - In Manitoba, around half of First Nations and Metis youth (ages 18-24) self-report their mental health as excellent or very good. 53% First Nations males and 49% First Nations females report their mental health as excellent or very good, as do 59% Metis males and 56% Metis females).
  - Almost half of Grades 9-12 students are at risk for future mental health problems.
  - In Manitoba, 24% of young women and 16% of young men (ages 15-19) report significant levels of stress in their lives.
  - Fewer Manitoba First Nations and Metis youth (ages 15-24) report stress than their counterparts in Canada, and than non-Indigenous youth in Manitoba and Canada.

- Since 2003, youth smoking in Manitoba has dropped by half, from 14% to 7% (in 2014), similar to Canada. Over half of Manitoba youth smokers do so daily.
  - Smoking is more common among Manitoba’s First Nations (35%) and Metis (27%) youth ages 12-24, (in 2011/14)
- In the past month, half of Manitoba Grade 12 students report having at least one alcoholic drink, 38% drank on 1 to 5 days, and 12% drank 6 or more days per week.
  - Alcohol use increases by age: 17% of Grade 9 students and 50% of Grade 12 students have had at least one drink in the past month.
  - One in eight Grade 12 students reported drinking and driving.
- In Manitoba, over a third of Grade 11-12 students have used recreational or prescription drugs to get high in the past year. The rates were similar for males and females, 37% males and 34% females in Grade 12. This increases with age, from approximately one in five Grade 9 students.
  - One in five Grade 7-12 students use marijuana/hashish to get high.
- Mood and anxiety disorders in youth (ages 13-19) are on the rise, particularly for girls.
  - In Manitoba, nearly four times as many 15- to 17-year-old girls (15%) report major depression, compared to boys (4%). These rates higher compared with Canada overall.
- In Manitoba, suicide is the leading cause of injury deaths (intentional and unintentional) in children ages 10 and up. The suicide rate is stable at 74/100,000 for 13- to 19-year-olds.
  - Girls are more likely to complete suicide than boys.
  - Suicide deaths are associated with prior inconsistent school attendance, hospitalization for suspicious injuries, criminal justice system involvement, documented suicidal ideation, parental and youth substance abuse, and frequent placement moves.
  - For Manitoba First Nations youth (ages 15-24), the suicide rates are five times higher for boys and seven times higher for girls, compared to the national average.
  - Almost one in five youth (ages 12-17) in First Nations communities have contemplated suicide, and one in ten (10%) have attempted suicide at least once.
  - Across Manitoba, three times as many girls (ages 13-19) have attempted suicide, compared to boys. Suicide attempts are more prevalent in rural/northern (vs. urban) and lower-income (vs. higher-income) communities.
- Youth (ages 15-19) injury hospitalization rates are decreasing over time. Motor vehicle collisions are the leading cause of unintentional injury hospitalization.
- Youth mobile crisis calls and crisis stabilization unit admissions may be on the rise across Manitoba. Over the past 18 years, youth psychiatric consultations in the Children’s Hospital emergency department have quintupled.
- Compared to young men, young women (ages 15-24) report higher rates of dating violence, twice as high in Manitoba (16% for controlling/emotional abuse and 10% for physical/sexual abuse) than Canada (7% and 5%, respectively).
  - In Manitoba, these rates are similarly higher for Indigenous youth, compared to non-Indigenous youth, and higher than Canada. (In 2014, 12% of Indigenous youth age 15 to 24 reported being victims of emotional abuse in a relationship, and 8% reported experiencing physical/sexual abuse.)
- In both Manitoba and Canada, one in four (26% in Manitoba and 27% in Canada) youth (ages 15-24) is a victim of crime (excluding spousal or dating violence).

- In Manitoba, three times as many Indigenous youth (ages 15-24) witnessed family violence before age 15 (14%), compared to non-Indigenous youth (4%).
- The majority of Manitoba Grade 9-12 students feel safe in their home (98%), school (90%), and community (88%).
  - However, the majority of transgender and gender diverse youth in Manitoba feel unsafe at school (64%). Many experience harassment, bullying, and sexual assault.
- More than a third (39%) of all Manitoba Grade 9-12 students have been body-shamed or bullied, taunted, or ridiculed.
  - One in four have been physically threatened/injured (27%) or subjected to racism (23%).
  - Girls are more likely to be socially or cyberbullied than boys, whereas boys are more likely to be physically bullied. While verbal, social, and physical bullying all decline with age, cyberbullying remains steady from Grades 7-12 in Manitoba.
- Manitoba 18- and 19-year-old youth represent nearly 3% of all people on Employment and Income Assistance (EIA). Youth on EIA represent 5% of all youth in Manitoba.
- Over 3,000 youth (ages 13-18) live in subsidized housing. One in ten (10%) Manitoba youth (ages 15-29) live in core housing need, with higher rates for First Nations, Metis, and Inuit peoples. (34% of Manitoba Status Indians, 24% of non-Status Indians, 21% Inuit and 15% Metis.)
- More than a quarter (1,400 - 27%) of Winnipeg homeless people are youth (ages 16-29): the majority are Indigenous and have spent time in Child and Family Services (CFS).
- Since 2006, nearly thirteen times as many permanent youth wards of CFS have received support from age 18 to 21, that is beyond termination of guardianship. 917 youth received this support in 2017.
- The majority of Manitoba Grade 9 students attain a Mathematics credit (88%) and English Language Arts credit (90%) by the end of the year. 93% and 94% of non-Indigenous and 69% and 74% of Indigenous students, respectively, achieve this credit.
- Average marks for Manitoba Grade 12 provincial exams have been stable over the past decade: between 50%-60% for applied or essential mathematics, between 60%-70% for pre-calculus mathematics, between 60%-70% for language arts. The average marks are slightly higher for French in Français and French Immersion programs.
- In 2015, on the international PISA exams\* (\*Organisation for Economic Co-operation and Development (OECD) Programme for International Student Assessment (PISA)), 83% of Manitoba 15-year-olds performed at the baseline level of science proficiency, compared to 89% in Canada and 79% across OECD countries.
  - On PISA reading literacy, Manitoba youth scored higher than the OECD average but lower than the Canadian average, with girls doing better than boys.
  - On PISA mathematics literacy, Manitoba scored lower than both the OECD and Canadian averages, with girls and boys doing similarly.
- In 2016, 78% of all Manitoba students graduated from high school “on time” (within four years of entering Grade 9); this reflects 81% of girls, 76% of boys, 86% of non-Indigenous students, and 48% of Indigenous students.
- In 2014/15, nearly 40,000 Manitoba youth under age 25 (57% were female and 43% were male) were enrolled in post-secondary education.
  - Over the past decade, female enrolments increased by 26% and male enrolments by 24%.

- Over half of Manitoba First Nations youth (ages 12-17) understand or speak a First Nations language.
- Most Manitoba Grade 9-12 students feel they belong at school (84%) and have at least one close friend (94%).
  - Most feel the adults at school care about them and can be trusted (75%-83%), but fewer (64%) would talk to a counsellor or other adult if they needed help.
- About half of Manitoba youth (ages 15-24) feel satisfied with their level of communication with friends or relatives. The rates are similar between young men (46%) and women (48%).
- In Manitoba, two-thirds (66%) of First Nations youth (ages 12-17) participate in local community cultural events.
- One in two (47%) Manitoba young men and four in five (78%) Manitoba young women (ages 15-24) volunteer, similar to and higher than Canada, respectively.
- Manitoba youth employment rates (ages 15-19) have been steadily declining over the past decade, for both males and females. (Males dropped from 53% to 40%, females decreased from 55% to 46%) For ages 17-24 years, 64% of men and 49% of women in Manitoba were employed full-time, rates that have steadily declined over the past four decades from 82% and 62%, respectively.
- Over the past decade, youth crime rate has declined in both Manitoba and Canada, with the Manitoba rate (4,362 per 100,000) twice as high as the Canadian rate. The Manitoba youth (age 12-17) incarceration rate is up to four times as high as the Canadian rate.

## **Conclusion**

This Report on the status of Manitoba's children and youth provides comprehensive information on our province's progress in improving the lives of our youngest citizens over the past decade and longer. There is extensive evidence and data to support the cross-departmental priorities recently identified by the Healthy Child Committee of Cabinet: truth and reconciliation, early childhood development, child and youth mental health, literacy and numeracy, children in care, and transitions for vulnerable youth. Indicators in this report can be used as baselines and benchmarks to inform future action and to continue measuring results, toward the Manitoba government's commitment to become the most improved province in Canada

## Résumé

« La santé est plus que l'absence de maladie – c'est une ressource humaine en évolution qui aide les enfants, les jeunes et les adultes à s'adapter aux difficultés de la vie quotidienne, à résister aux blessures et à l'adversité, à ressentir un bien-être personnel et à interagir avec leur environnement de façon à favoriser un développement positif...la santé des enfants est la richesse d'une nation, car un corps et un esprit sains renforcent la capacité des enfants à acquérir les compétences variées qui sont nécessaires pour qu'ils deviennent des membres actifs d'une société productive. » (*traduction*) Source : Center on the Developing Child at Harvard University. The foundations of lifelong well-being are built in early childhood, 2010. <http://www.developingchild.harvard.edu>

### Introduction

La santé et le bien-être des enfants et des jeunes du Manitoba est déterminée dans une large mesure par leur développement au cours de la jeune enfance. Nous avons tous un rôle à jouer pour limiter les risques et renforcer les aspects qui protègent les enfants, les familles et les collectivités du Manitoba. Il est largement prouvé qu'investir dans le bien-être des enfants entraîne des bénéfices financiers importants.

En mars 2016, le Manitoba a adopté la *Loi sur la réconciliation* afin de favoriser la réconciliation dans la province. Cette loi exige que le Manitoba établisse une stratégie de réconciliation qui s'appuie sur un engagement solide avec les peuples autochtones et tous les Manitobains.

Le rapport de 2017 est le deuxième rapport public sur la situation des enfants et des jeunes du Manitoba. Ces rapports doivent être publiés tous les cinq ans, conformément aux dispositions de la *Loi sur la stratégie « Enfants en santé Manitoba »*. Le rapport est organisé en fonction de quatre stades du développement des enfants et des jeunes (stade prénatal, jeune enfance, enfance intermédiaire, adolescence) et de quatre objectifs fixés par la stratégie Enfants en santé Manitoba (santé physique et affective, sécurité, succès en ce qui concerne l'apprentissage et engagement et responsabilisation dans le domaine social).

Chaque chapitre aborde les indicateurs clés à chaque stade pour chacun des objectifs. Dans la mesure du possible, nous avons ajouté les tendances au cours des années, ainsi que les données comparatives pour l'ensemble du Canada et les renseignements par genre, situation socio-économique, région et origine ethnique. Le rapport fournit des données descriptives visant à informer la population manitobaine des progrès accomplis et des priorités pour l'avenir.

### Chapitre 2 – Qui sont les enfants du Manitoba?

- Les enfants et les jeunes (âgés de 0 à 19 ans) représentent un quart de la population du Manitoba (25,3 %, plus de 335 000 personnes), une proportion plus élevée que dans l'ensemble du Canada (22 %). Au cours de la dernière décennie, le nombre d'enfants de 0 à 4 ans a augmenté de 21 %.
- Plus de la moitié des enfants et des jeunes du Manitoba (56 %) vivent en milieu urbain.



- Depuis 2000, la plupart des enfants et des jeunes du Manitoba (76 %) vivent avec deux parents. Une proportion plus grande d'enfants et de jeunes vivent dans des familles monoparentales (24 %), par comparaison avec le Canada (21 %).
- Les jeunes de notre province ont des cultures, des origines ethniques, des identités et des langues variées.
  - Plus d'un sur quatre (29 %) (90 000 enfants âgés de 0 à 19 ans) sont autochtones (membres d'une Première nation, Métis ou Inuits), un chiffre presque quatre fois plus élevé que pour le Canada dans son ensemble et qui augmente avec le temps. Trente pour cent des enfants manitobains de 0 à 5 ans sont autochtones, comparé à 8 % au Canada.
  - Depuis 2012, le nombre d'enfants et de jeunes nouvellement arrivés au Manitoba pour y vivre de façon permanente et qui sont nés dans d'autres pays a augmenté de 33 %. Par comparaison avec le Canada dans son ensemble, le Manitoba a une proportion plus élevée de nouveaux arrivants jeunes.
  - Les langues non officielles les plus parlées au Manitoba sont le tagalog, l'allemand, le pendjabi, le cri, l'ojobwa, l'espagnol et le mandarin.
  - Un jeune manitobain sur cinq fait partie d'une minorité visible.
- Depuis 2001, le nombre d'enfants pris en charge a augmenté, passant de 1,9 % à 3,5 % du total des enfants; les enfants en question sont en très grande partie autochtones.
- La situation socio-économique est un facteur important pour le développement d'un enfant. La situation socio-économique au cours de la jeune enfance peut jouer un rôle important pour permettre de prédire le développement du cerveau, l'apprentissage, le comportement et d'autres aspects de la santé d'un enfant. Les enfants qui vivent dans un milieu socio-économique défavorisé sont plus susceptibles d'avoir des expériences négatives dans l'enfance et de ressentir un stress préjudiciable.
- Les enfants issus de certains groupes démographiques sont plus susceptibles de vivre dans la pauvreté que la population dans son ensemble. Il existe des niveaux de pauvreté extrême parmi les familles monoparentales et les familles autochtones, particulièrement les familles des Premières nations qui habitent dans des réserves, où la pauvreté infantile est très marquée. La pauvreté entraîne des difficultés en ce qui concerne l'accès à une alimentation nutritive, ainsi qu'à des logements convenables et abordables, ce qui intensifie les risques pour la santé des enfants.
  - On considère comme une condition préalable à la bonne santé le fait d'avoir un logement convenable, et ceci est particulièrement important pour les jeunes enfants.
  - « Insécurité alimentaire » est l'expression qui décrit le fait d'avoir faim dans les pays riches; ceci est un déterminant important de la santé des enfants, y compris en ce qui concerne les maladies chroniques et les maladies mentales.
  - Lorsque les parents ont un niveau d'éducation élevé, le développement des enfants est en général nettement influencé de façon positive, pour ce qui est, entre autres, de la maturité à l'entrée à l'école, de la réussite à l'école, de la santé et des activités prosociales.
- Au Manitoba, entre 12 % et 22 % des enfants sont pauvres – selon la mesure utilisée –, ce qui est un taux plus élevé que dans l'ensemble du Canada.
  - Les enfants de familles monoparentales dirigées par une femme ont jusqu'à quatre fois plus de risques d'être pauvres que les enfants dont les familles ont un couple à leur tête.

- Un enfant des Premières nations sur deux, un enfant métis sur quatre, un enfant inuit sur quatre et un enfant non-autochtone sur six vit dans la pauvreté au Manitoba, ces chiffres étant tous plus élevés que ceux du Canada dans son ensemble.
  - Au Manitoba, il y a moins de parents qui ont terminé des études secondaires ou postsecondaires (47 %) qu’au Canada dans son ensemble (56 %).
  - Moins de familles vivent dans un logement inadéquat situé dans le centre d’une ville (10-11 %) au Manitoba qu’au Canada (13 %). Les enfants autochtones sont plus susceptibles de vivre dans des logements ayant besoin de grosses réparations.
- Les enfants qui connaissent l’insécurité alimentaire sont plus nombreux au Manitoba (11 % en 2012) qu’au Canada (10 % in 2012).

### **Chapitre 3 – Stade prénatal**

La santé et le bien-être des parents qui attendent un enfant influent sur la santé, le bien-être et le développement du bébé à naître. Les influences sont nombreuses : les facteurs sociaux et démographiques, le milieu social et physique, les relations et le soutien, et l’exposition ambiante. Ces influences peuvent être importantes et avoir un effet à long terme. La santé sociale et affective des parents et de la famille est un facteur important pour leur bien-être et pour la santé des nouveaux-nés. Lorsque les familles et les communautés sont encourageantes, le risque de problèmes peut être atténué.

- La situation socio-économique est un facteur important pour une bonne grossesse et un bébé en santé. Lorsque les parents ont des revenus et un niveau d’études élevés, les résultats obtenus sont meilleurs.
- L’alimentation de la mère pendant la grossesse a une influence sur sa santé et sur le bon développement du fœtus. La consommation d’alcool, de tabac et d’autres drogues pendant la grossesse peut entraîner des difficultés pour le bébé et pour son développement jusqu’à l’âge adulte.
- Lorsqu’une femme a des problèmes de santé mentale pendant la grossesse, son enfant court davantage de risques d’avoir des troubles mentaux et du développement.
- La plupart des mères du Manitoba (78 %) sont de jeunes adultes lorsqu’elles mettent leurs enfants au monde (entre 20 et 34 ans), comme dans l’ensemble du Canada. Le Manitoba a une proportion plus élevée de jeunes mères (entre 15 et 19 ans), tandis qu’au Canada, c’est la proportion de mères plus âgées (35 ans et +) qui est plus élevée.
- Les grossesses chez les adolescentes et le taux de natalité continuent à baisser petit à petit au Manitoba; ces chiffres restent plus élevés dans le Nord et plus bas dans la partie sud de la province.
- De moins en moins de bébés (en dehors des réserves) naissent dans des conditions socio-économiques difficiles. Par exemple, les mères qui ont fait des études secondaires sont plus nombreuses (85 % en 2015, par rapport à 78 % en 2003) et les familles ayant des problèmes financiers sont passées de 18 % en 2003 à 14 % en 2015.
- Cependant, au fil des années, de moins en moins de femmes du centre-ville de Winnipeg et du Nord, où les besoins sont les plus forts, reçoivent des soins prénatals.
- La consommation d’alcool et de tabac, ainsi que les problèmes relationnels pendant la grossesse ont diminué au fil des années au Manitoba, mais les cas de dépression ou d’anxiété sont en hausse chez les mères.
  - La consommation d’alcool est passée de 14 % en 2003 à 10 % en 2015.

- La consommation de tabac pendant la grossesse est passée de 21 % en 2003 à 13 % en 2015.
- Les problèmes relationnels sont passés de 6 % en 2003 à 4 % en 2015.
- Les cas de dépression et d’anxiété sont passés de 13 % en 2003 à 18 % en 2015.
- L’ensemble des troubles causés par l’alcoolisation foetale (ETCAF) est appelé « une déficience invisible », parce que la majorité des personnes touchées n’ont pas les traits faciaux associés à ces troubles.
- L’exposition à l’alcool entraîne l’ETCAF ou ne l’entraîne pas, en fonction de facteurs biologiques et sociaux qui agissent les uns sur les autres de façon différente selon les personnes. Les facteurs biologiques peuvent être : la réactivité de la femme à l’alcool, son métabolisme et sa corpulence. Des facteurs sociaux comme le stress chronique, la violence, les traumatismes ou la pauvreté peuvent accroître les risques que le bébé soit atteint de ces troubles.

#### **Chapitre 4 – Stade de la jeune enfance (de la naissance à l’âge de 5 ans)**

Les cinq premières années de la vie constituent une période importante et délicate qui peut avoir une influence profonde sur l’avenir d’un enfant. Au cours de la jeune enfance, le développement du cerveau est très sensible à toutes les expériences, qu’elles soient positives ou négatives. Il est important, pour qu’un enfant se développe bien, que son environnement social, affectif et physique soit sain.

- Le nombre de naissances prématurées et de bébés ayant un faible poids à la naissance est relativement stable au Manitoba et semblable aux chiffres du Canada.
- Comparé au Canada, le Manitoba a une plus grande proportion de bébés nés gros pour leur âge gestationnel, mais ce chiffre semble baisser plus vite au Manitoba.
- L’allaitement précoce et l’allaitement exclusif se sont répandus au Manitoba au fil des ans, et les taux sont maintenant plus élevés que ceux du Canada.
  - Le taux d’allaitement précoce est passé de 84 % en 2007-2008 à 93 % en 2011-2012.
  - Le taux d’allaitement exclusif pendant six mois au moins est passé de 25 % en 2007-2008 à 31 % en 2011-2012. Le taux canadien était de 26 % en 2011-2012.
- Les extractions dentaires et les opérations chirurgicales chez les enfants de moins de 6 ans ont diminué dans les dix dernières années.
  - Le taux d’extractions dentaires chez des enfants de moins de six ans était de 18 pour 1000 en 2006-07 et de 11 pour 1000 en 2015-16.
- Le taux de vaccination parmi les enfants de deux ans est relativement stable, mais il demeure plus bas chez les enfants issus de familles des Premières nations, de familles à faible revenu ou de familles dirigées par des mères adolescentes.
- Dans les dix dernières années, la santé et le bien-être physiques, ainsi que la maturité affective des enfants de la maternelle au Manitoba est demeurée stable et à un niveau semblable à celui du Canada.
- Le taux d’hospitalisation de bébés de moins d’un an pour cause de blessure semble augmenter, tandis que ce même taux semble diminuer pour ce qui est des enfants d’âge préscolaire (de 1 à 4 ans), la cause principale des hospitalisations étant une chute.
- La mortalité infantile continue à être plus élevée au Manitoba que dans le reste du Canada, surtout dans le Nord.

- Entre 2010-2011 et 2014-2015, le taux brut de mortalité infantile au Manitoba était de 5,9 pour 1000 naissances vivantes. Ceci variait selon la région, le taux le plus élevé étant dans le Nord (10,9) et le plus bas dans la région sud (4,8).
- Un enfant manitobain de moins de six ans sur trois vit dans la pauvreté (ce qui est 1,7 fois plus élevé que le chiffre du Canada) et un enfant sur huit vit en situation d’insécurité alimentaire, ce qui est aussi un taux plus élevé que le taux canadien.
- En 2016-2017, 1371 enfants et jeunes de moins de 18 ans se sont réfugiés dans un abri d’urgence financé par le gouvernement du Manitoba pour des raisons de violence familiale. Ce chiffre a subi quelques fluctuations au cours des cinq années qui précédaient.
- Les enfants de moins de six ans sont plus nombreux à avoir accès à des places dans un programme d’apprentissage et de garde des jeunes enfants. Environ trois enfants d’âge préscolaire sur quatre n’y ont pas accès.
- Au cours des dix dernières années, le développement langagier et cognitif (littératie et numératie) des enfants manitobains de la maternelle est resté stable à l’échelle provinciale, mais avec des différences importantes en fonction des communautés.
- La maturité scolaire des enfants qui commencent la maternelle est restée stable au fil du temps. Plus d’un enfant sur quatre n’était pas prêt pour ce qui est d’un aspect du développement précoce ou plus (le développement physique, social, affectif et cognitif, et les connaissances générales).

## **Chapitre 5 – Stade de l’enfance intermédiaire (de 6 à 14 ans – de la 1<sup>ère</sup> à la 8<sup>e</sup> année)**

L’enfance intermédiaire est une période où les enfants passent par des étapes importantes de leur développement. Pour les enfants de 6 à 14 ans, il s’agit de l’acquisition et du perfectionnement de compétences physiques, affectives et sociales et de l’aptitude à l’apprentissage. Sur le plan physique, les enfants continuent à se développer rapidement et leur cerveau se développe aussi. Ces changements leur permettent de s’investir dans le monde et de l’explorer de façon différente et plus complexe. La puberté commence vers la fin des années intermédiaires, entre 11 et 14 ans.

- L’asthme reste la maladie chronique la plus répandue à ce stade, et il semble que les cas augmentent avec le temps. Il est deux ou trois fois plus courant chez les enfants métis et des Premières nations.
  - En 2013-2014, 9 % des garçons et 11 % des filles du Manitoba avaient de l’asthme, comparé à 13 % des garçons et 9 % des filles au Canada.
- La prévalence du trouble déficitaire de l’attention avec hyperactivité (TDAH) augmente avec le temps; il en va de même pour le trouble du spectre de l’autisme (TSA).
  - Chez les enfants de 6 à 12 ans, la prévalence du TDAH était de 7,5 % entre 2005-2006 et 2008-2009 et de 8,7 % entre 2009-2010 et 2012-2013.
  - Chez les enfants de 6 à 12 ans, la prévalence vie-entière de TSA diagnostiqué était de 1,2 % entre 2005-2006 et 2008-2009 et de 1,5 % entre 2009-2010 et 2012-2013.
- Il est important pour les enfants à n’importe quel stade de leur développement que l’on pose un diagnostic en ce qui concerne l’ETCAF. Les techniques éducatives et parentales courantes peuvent ne pas être efficaces et entraîner de la frustration pour les enfants atteints de l’ETCAF et les adultes. En ayant des renseignements clairs au sujet de ce trouble, les parents, les enseignants et les autres professionnels peuvent intervenir de façon

adaptée et solliciter une aide qui convienne à l'enfant. En passant de l'idée de « travailler plus fort » à celle de « travailler différemment », les parents et les personnes qui s'occupent d'enfants atteints de l'ETCAF peuvent plus facilement chercher des façons d'aider ces enfants à apprendre, à se développer et à s'adapter (<http://fasdmanitoba.com-assessment>).

- Les deux tiers environ des enfants de 7 ans du Manitoba ont eu tous les vaccins recommandés. C'est la région du Nord qui a le taux de vaccination le plus élevé (74 %).
- Les deux tiers des élèves manitobains de 7<sup>e</sup> et de 8<sup>e</sup> année ont un poids santé. D'autres données indiquent que le surpoids et l'obésité ont augmenté au cours des années parmi les enfants du Manitoba âgés de 12 à 19 ans, pour atteindre 26 %, ce qui est plus élevé que le chiffre canadien.
  - La moitié seulement des élèves manitobains de 7<sup>e</sup> et de 8<sup>e</sup> année sont actifs pendant les 60 minutes par jour recommandées, et un sur six est inactif tous les jours.
  - 15 % des élèves de 7<sup>e</sup> et de 8<sup>e</sup> année sont inactifs.
- Moins de 40 % des élèves de 7<sup>e</sup> et de 8<sup>e</sup> année dorment 9 heures par nuit pendant la semaine d'école, comme on le recommande.
- Bien des élèves passent 3 heures ou plus devant un écran chaque jour de la semaine (40 %) et les fins de semaine (60 %).
- Moins de la moitié des élèves de 7<sup>e</sup> et de 8<sup>e</sup> année mangent le nombre de fruits et de légumes recommandé quotidiennement.
- Plus d'un tiers des élèves de 7<sup>e</sup> et de 8<sup>e</sup> année risquent d'avoir des problèmes de santé mentale dans l'avenir. De plus, 31 % des garçons et 43 % des filles ont indiqué qu'ils s'étaient sentis si tristes ou sans espoir au cours de l'année qu'ils avaient cessé leurs activités habituelles pendant un moment.
  - Les troubles anxieux ou de l'humeur ou les troubles des conduites diagnostiqués semblent être en hausse chez les enfants de 6 à 12 ans, surtout dans les collectivités à faible revenu.
    - Le taux de prévalence sur quatre ans des troubles anxieux et de l'humeur diagnostiqués parmi les enfants de 6 à 12 ans était de 1,8 % entre 2005-2006 et 2008-2009, et de 2,2 % entre 2009-2010 et 2012-2013.
    - Le taux de prévalence sur quatre ans des troubles des conduites diagnostiqués parmi les enfants de 6 à 12 ans était de 1,9 % entre 2005-2006 et 2008-2009, et de 2,1 % entre 2009-2010 et 2012-2013.
  - Un élève de 5<sup>e</sup> année sur cinq indique avoir eu au moins un problème mental.
- Les hospitalisations pour blessures accidentelles semblent décliner chez les enfants du stade intermédiaire, les chutes étant la cause principale de ces blessures (comme pour les jeunes enfants).
  - Le taux d'hospitalisation pour blessure parmi les enfants âgés de 5 à 9 ans était de 1,4 pour 1000 en 2015-2016.
  - Les collisions d'automobiles continuent à être la principale cause de décès à la suite de blessures accidentelles.
- Le taux de violence familiale signalée à la police chez les enfants et les jeunes de 0 à 17 ans est plus élevé au Manitoba qu'au Canada. Ce taux est plus élevé chez les filles que chez les garçons.
  - En 2015, le taux de violence familiale signalée à la police chez les enfants et les jeunes de 0 à 17 ans était de 374 pour 100 000 au Manitoba.

- Presque un tiers des élèves de la 4<sup>e</sup> à la 6<sup>e</sup> année signalent qu'ils ont été victimes d'intimidation verbale, sociale ou physique ou de cyberintimidation. Le chiffre est le même en ce qui concerne les élèves de 7<sup>e</sup> et 8<sup>e</sup> année (ridicule, dénigrement de leur apparence, menaces ou blessures physiques, racisme).
- L'exposition des enfants de moins de 12 ans à la fumée secondaire chez eux a diminué au cours de la dernière décennie.
- Presque la moitié (42 %) des enfants et des jeunes qui vivent dans des logements sociaux ont entre 6 et 12 ans.
  - Il y a plus d'enfants de moins de 15 ans qui vivent dans des logements inadéquats dans un centre-ville (16 %) au Manitoba qu'au Canada (14 %). Les enfants de familles monoparentales sont quatre fois plus susceptibles de vivre dans des logements inadéquats dans un centre-ville que les enfants de familles ayant un couple à leur tête.
- L'insécurité alimentaire chez les enfants de 6 à 17 ans semble décliner au Manitoba, mais elle est toujours plus élevée que dans l'ensemble du Canada.
  - Il y a plus d'enfants manitobains métis et des Premières nations âgés de 6 à 14 ans qui vivent dans des foyers ayant un niveau de sécurité alimentaire faible ou très faible qu'au Canada dans son ensemble.
  - Au Manitoba, en 2011-2012, 10 % des enfants âgés de 6 à 17 ans vivaient dans des foyers avec un niveau d'insécurité alimentaire modérée ou grave.
  - Au Manitoba, en 2012, 26 % des foyers des Premières nations ayant des enfants de 6 à 14 ans avaient un niveau de sécurité alimentaire faible ou très faible, et 20 % des foyers métis ayant des enfants de 6 à 14 ans étaient dans le même cas.
- De manière générale, les résultats des évaluations scolaires au niveau intermédiaire se sont améliorés parmi les élèves du Manitoba.
  - Cependant, moins de la moitié des élèves sont au niveau prévu pour ce qui est de la numératie de 3<sup>e</sup> année et des mathématiques de 7<sup>e</sup> année, et seul un élève autochtone sur six répond à ces mêmes attentes.
  - En gros, entre 40 et 60 % des élèves répondent aux attentes pour ce qui est de tous les aspects de la lecture en 3<sup>e</sup> et 4<sup>e</sup> année et de la compréhension de lecture en 8<sup>e</sup> année, et seul un élève autochtone sur six répond à ces mêmes attentes.
- Le nombre d'enfants éduqués à domicile au Manitoba a presque quadruplé (3,7x) depuis 2002.
- Au Manitoba, 70 % des enfants des Premières nations et 40 % des enfants métis âgés de 6 à 14 ans pensent qu'il est assez ou très important de parler une langue autochtone.
  - Le nombre d'élèves manitobains inscrits à des programmes de langues autochtones dans les écoles publiques a augmenté de 23 % entre 2001-2002 et 2014-2015.
- La plupart des enfants manitobains âgés de 12 à 14 ans ont un sentiment d'appartenance à leur collectivité locale.
- La plupart (80 %) des élèves de 5<sup>e</sup> année du Manitoba ont des comportements sociaux positifs (ils sont prévenants, ils partagent, ils aident, ils sont gentils avec les autres).
- Entre 40 % et 60 % des élèves de 7<sup>e</sup> année sont impliqués de façon compétente dans l'apprentissage scolaire, d'après les évaluations faites par les enseignants.
- D'après une auto-évaluation faite par les élèves de 7<sup>e</sup> et de 8<sup>e</sup> année, plus de 80 % d'entre eux se sentent en sécurité et ont un sentiment d'appartenance à l'école; ils pensent également que les adultes de l'école sont bienveillants et dignes de confiance.
  - 91 % ont un sentiment d'appartenance et se sentent en sécurité à l'école;

- 90 % sentent qu’ils font partie de l’école;
- 87 % sont contents d’être à l’école;
- 85 % se sentent proches des membres de la communauté scolaire.
- Trois élèves de 7<sup>e</sup> et de 8<sup>e</sup> année sur quatre s’adresseraient à une conseillère, un conseiller ou un autre adulte s’ils avaient besoin d’aide.
- Un élève manitobain de 5<sup>e</sup> année sur six (15 %) a des problèmes mineurs ou importants dans le domaine des relations avec ses camarades (l’élève n’a pas même un ami ou une amie proche, ou se fait harceler, par exemple).

## **Chapitre 6 – Le stade de l’adolescence (de 13 à 19 ans – de la 7<sup>e</sup> à la 12<sup>e</sup> année)**

L’adolescence est une période importante de transition et de transformation où les rôles, les relations et les attentes changent. On s’attend à ce que les jeunes, à ce stade, deviennent plus indépendants et responsables. En même temps, ils vivent des changements physiques et émotionnels profonds, et ressentent une pression croissante de la part de la société et de leurs pairs. Cette période est aussi consacrée à l’exploration, et les expériences vécues et les comportements adoptés peuvent avoir des effets à long terme jusqu’à l’âge adulte.

- Au Manitoba, environ deux tiers (63 %) des adolescents de 15 à 19 ans estiment que leur santé est excellente ou très bonne, ce qui est plus bas que dans l’ensemble du Canada (70 %). Plus de filles (64 %) que de garçons (61 %) déclarent que leur santé est excellente ou très bonne.
- Le Manitoba a l’un des taux de diabète de type 2 chez les enfants le plus haut du monde. Il est 12 fois plus élevé que le taux existant dans n’importe quelle autre province du Canada.
- La prévalence du trouble déficitaire de l’attention avec hyperactivité (TDAH) parmi les adolescents de 13 à 19 ans est en hausse. Dans la période allant de 2009-2010 à 2012-2013, la prévalence était de 4,8 %. Le chiffre est plus de deux fois plus élevé parmi les garçons que parmi les filles.
- La prévalence du trouble du spectre de l’autisme (TSA) et d’autres troubles du développement chez les adolescents de 13 à 19 ans est également en hausse. Entre 2009-2010 et 2012-2013, la prévalence de TSA était de 1,2 %.
- Près des trois quarts des adolescents manitobains de 12 à 19 ans sont actifs physiquement pendant leurs loisirs, tout comme dans l’ensemble du Canada.
  - Plus les jeunes du Manitoba vieillissent, moins ils sont susceptibles de faire les 60 minutes quotidiennes recommandées d’activité physique : en 7<sup>e</sup> année, 51 % des adolescents atteignent ce chiffre et en 12<sup>e</sup> année, le taux est de 39 %, les filles étant moins actives physiquement que les garçons à chaque niveau scolaire.
  - Pour ce qui est des jeunes manitobains âgés de 12 à 24 ans, l’activité physique varie selon les groupes : 62 % des jeunes des Premières nations étaient modérément actifs ou actifs (au cours de la période de 2011 à 2014), de même que 66 % des jeunes métis et 70 % des jeunes non autochtones.
- Plus de la moitié (54 %) des élèves manitobains de la 9<sup>e</sup> à la 12<sup>e</sup> année passent 3 heures et plus devant un écran pendant la semaine, et les deux tiers d’entre eux (67 %) font de même pendant les fins de semaines. Les élèves les plus âgés passent plus de temps devant un écran que les plus jeunes.
- Le surpoids et l’obésité sont en hausse. Deux tiers des garçons et trois quarts des filles de la 9<sup>e</sup> à la 12<sup>e</sup> année ont un poids santé.

- Seuls 14 % des élèves manitobains de la 9<sup>e</sup> à la 12<sup>e</sup> année dorment 9 heures pendant les nuits de semaine, comme il est recommandé.
- Trois pour cent des élèves manitobains de la 7<sup>e</sup> à la 12<sup>e</sup> année déclarent être transgenres et 5 % ont remis leur identité de genre en question. Cinq pour cent des élèves ont déclaré être attirés aussi bien par les hommes que par les femmes, et 2 % ont déclaré être attirés par des personnes du même sexe.
- Les trois quarts (74 %) des élèves manitobains de la 7<sup>e</sup> à la 12<sup>e</sup> année indiquent qu'ils n'ont pas eu de relations sexuelles. Le chiffre baisse à mesure que l'âge croît : 96 % en 7<sup>e</sup> année et 51 % en 12<sup>e</sup> année.
  - L'âge le plus courant pour la première relation sexuelle était 15 ans (24 %).
  - Le moyen de contraception le plus couramment utilisé était le préservatif (81 %), et 13 % ont indiqué ne pas utiliser de moyen de protection.
  - Parmi les élèves qui ont déclaré avoir eu des relations sexuelles, 17 % ont dit qu'ils ou elles ne voulaient pas avoir ces relations à ce moment-là.
  - La moitié (51 %) des élèves étaient assez à l'aise pour discuter de contraception avec leur partenaire; plus d'un tiers (37 %) ont déclaré avoir eu des relations sexuelles non prévues, après avoir consommé de l'alcool ou de la drogue au cours de l'année passée.
  - Le taux d'infections transmissibles sexuellement continue à être élevé chez les jeunes manitobains de 15 à 19 ans. Entre 2012 et 2016, les ITS les plus répandues étaient la chlamydia et la gonorrhée. Le taux de chlamydia parmi les jeunes du Manitoba âgés de 15 à 19 ans était de 1947 pour 100 000 personnes en 2016. Ce taux avait baissé entre 2012 et 2014, mais a augmenté en 2016. Le taux de gonorrhée parmi les jeunes du Manitoba âgés de 15 à 19 ans était de 539 pour 100 000 en 2016, une augmentation de 35 % par rapport à 2012, où le chiffre était de 398 pour 100 000.
- Trois jeunes manitobains âgés de 15 à 17 ans sur quatre (74 %) s'auto-évaluent comme ayant une santé mentale excellente ou très bonne, ce chiffre étant plus bas (les deux tiers, soit 62 %) chez les jeunes hommes de 18 et 19 ans, mais semblable (75 %) chez les jeunes femmes.
  - Au Manitoba, environ la moitié des jeunes métis et des Premières nations âgés de 18 à 24 ans déclarent avoir une santé mentale excellente ou très bonne; 53 % des jeunes hommes et 49 % des jeunes femmes des Premières nations déclarent avoir une santé mentale excellente ou très bonne, de même que 59 % des jeunes hommes métis et 56 % des jeunes femmes métisses.
  - Presque la moitié des élèves de la 9<sup>e</sup> à la 12<sup>e</sup> année risquent d'avoir des problèmes mentaux à l'avenir.
  - Au Manitoba, 24 % des jeunes femmes et 16 % des jeunes hommes de 15 à 19 ans indiquent qu'ils ont un stress marqué dans leur vie.
  - Les jeunes manitobains métis et des Premières nations âgés de 15 à 24 ans sont moins nombreux à dire qu'ils ressentent du stress que leurs homologues ailleurs au Canada et que les jeunes non autochtones du Manitoba et du Canada.
- Depuis 2003, la consommation de tabac chez les jeunes du Manitoba a diminué de moitié, passant de 14 % à 7 % (en 2014), ce qui est semblable au Canada dans son ensemble. Plus de la moitié des jeunes manitobains qui fument le font quotidiennement.
  - La consommation de tabac était plus répandue parmi les jeunes des Premières nations (35 %) et les jeunes métis (27 %) du Manitoba âgés de 12 à 24 ans, (entre 2011 et 2014)



- La moitié des élèves manitobains de 12<sup>e</sup> année indiquent avoir bu au moins une boisson alcoolisée au cours du mois passé; 38 % d'entre eux ont bu entre 1 et 5 jours par semaine et 12 % ont bu 6 jours ou plus par semaine.
  - La consommation d'alcool augmente avec l'âge : 17 % des élèves de 9<sup>e</sup> année et 50 % des élèves de 12<sup>e</sup> année ont bu au moins une boisson alcoolisée au cours du mois dernier.
  - Parmi les élèves de 12<sup>e</sup> année, un sur huit indique avoir conduit en ayant bu de l'alcool.
- Au Manitoba, plus d'un tiers des élèves de 11<sup>e</sup> et de 12<sup>e</sup> année ont consommé des drogues à usage récréatif ou des médicaments obtenus sur ordonnance pour « planer » au cours de l'année passée. Les taux sont les mêmes chez les filles que chez les garçons : 37 % des garçons et 34 % des filles de 12<sup>e</sup> année. Ce taux augmente avec l'âge : en effet, il est de un sur cinq parmi les élèves de 9<sup>e</sup> année.
  - Un élève de la 7<sup>e</sup> à la 12<sup>e</sup> année sur cinq consomme de la marijuana ou du hashish pour « planer ».
- Les troubles anxieux et de l'humeur chez les jeunes de 13 à 19 ans sont en hausse, surtout chez les filles.
  - Au Manitoba, presque quatre fois plus de filles de 15 à 17 ans (15 %) que de garçons (4 %) disent avoir fait une dépression grave. Ces taux sont plus élevés que ceux du Canada dans son ensemble.
- Au Manitoba, le suicide est la principale cause de décès pour cause de blessure (accidentelle ou non) chez les enfants de 10 ans et plus. Le taux de suicide est stable : il est de 74 pour 100 000 parmi les jeunes de 13 à 19 ans.
  - Les filles sont plus susceptibles de réussir à se suicider que les garçons.
  - Les enfants qui meurent d'un suicide sont souvent des enfants qui fréquentaient l'école de façon irrégulière, qui avaient été hospitalisés pour blessures suspectes, qui étaient connus du système de justice pénale, qui avaient des idées suicidaires, qui abusaient, ou dont les parents abusaient d'alcool ou de drogue et qui avaient vécu des placements multiples.
  - Chez les jeunes des Premières nations âgés de 15 à 24 ans, le taux de suicide est cinq fois plus élevé chez les garçons et sept fois plus élevé chez les filles, comparé à la moyenne nationale.
  - Dans les collectivités des Premières nations, presque un jeune sur cinq âgé de 12 à 17 ans a songé au suicide et un sur dix (10 %) a fait une tentative de suicide au moins une fois.
  - Au Manitoba, trois fois plus de filles de 13 à 19 ans que de garçons ont fait une tentative de suicide. Les tentatives de suicide sont plus répandues dans les régions rurales et le Nord (comparé aux villes) et dans les collectivités à faible revenu (comparé aux collectivités à revenu plus élevé).
- Les cas d'hospitalisation pour cause de blessure chez les jeunes de 15 à 19 ans déclinent. Les accidents d'automobile sont la principale cause des hospitalisations pour blessure accidentelle.
- Les appels de jeunes en crise à un service d'urgence mobile et les admissions dans des services d'intervention d'urgence et de courte durée semblent être en hausse dans tout le Manitoba. Au cours des 18 dernières années, les consultations psychiatriques ont quintuplé au service d'urgence de l'Hôpital pour enfants.

- Par rapport aux jeunes hommes, les jeunes femmes de 15 à 24 ans sont plus souvent victimes de violence dans leurs fréquentations; ces chiffres sont deux fois plus élevés au Manitoba (16 % pour violence psychologique ou dominatrice et 10 % pour violence physique ou sexuelle) qu’au Canada (7 % et 5 %, respectivement).
  - Au Manitoba, ces taux sont également plus élevés chez les jeunes autochtones, par comparaison aux jeunes non autochtones, et plus élevés qu’au Canada. (En 2014, 12 % des jeunes autochtones de 15 à 24 ans ont indiqué avoir été victimes de violence psychologique dans leurs fréquentations et 8 % ont indiqué avoir été victimes de violence physique ou sexuelle).
- Au Manitoba comme au Canada, un jeune de 15 à 24 ans sur quatre (26 % au Manitoba et 27 % au Canada) a été victime d’un crime, sans compter la violence conjugale ou la violence dans les fréquentations.
- Au Manitoba, trois fois plus de jeunes autochtones de 15 à 24 ans ont été témoins de violence familiale avant l’âge de 15 ans (14 %) que de jeunes non autochtones (4 %).
- La majorité des élèves manitobains de la 9<sup>e</sup> à la 12<sup>e</sup> année se sentent en sécurité chez eux (98 %), à l’école (90 %) et dans leur communauté (88 %).
  - Cependant, la majorité des jeunes transgenres et qui ont des identités de genre diverses ne se sentent pas en sécurité à l’école au Manitoba (64 %). Nombre d’entre eux se font harceler, intimider et agresser sexuellement.
- Plus d’un tiers (39 %) de tous les élèves manitobains de la 9<sup>e</sup> à la 12<sup>e</sup> année ont subi des dénigrement à cause de leur apparence, ou ont été victimes d’intimidation, de railleries ou de ridicule.
  - Un sur quatre a été menacé physiquement ou blessé (27 %), ou victime de racisme (23 %).
  - Les filles sont plus susceptibles d’être victimes d’intimidation sociale ou de cyberintimidation, tandis que les garçons sont plus susceptibles d’être victimes d’intimidation physique. Les cas d’intimidation verbale, sociale et physique diminuent avec l’âge, mais la cyberintimidation reste au même niveau entre la 7<sup>e</sup> et la 12<sup>e</sup> année au Manitoba.
- Les jeunes manitobains de 18 et 19 ans représentent presque 3 % de toutes les personnes qui reçoivent des prestations d’aide à l’emploi et au revenu. Les jeunes qui reçoivent ces prestations constituent 5 % de tous les jeunes du Manitoba.
- Plus de 3000 jeunes âgés de 13 à 18 ans vivent dans des logements subventionnés. Un jeune manitobain âgé de 15 à 29 ans sur dix (10 %) vit dans un logement inadéquat dans un centre-ville, et ces taux sont plus élevés parmi les Premières nations, les Métis et les Inuits. (34 % des Indiens inscrits, 24 % des Indiens non inscrits, 21 % des Inuits et 15 % des Métis du Manitoba)
- Plus d’un quart (1400, soit 27 %) des personnes sans-abri de Winnipeg sont des jeunes de 16 à 29 ans, la majorité étant des Autochtones qui ont passé du temps dans le système des Services à l’enfant et à la famille.
- Depuis 2006, près de treize fois plus de jeunes qui avaient été pupilles des Services à l’enfant et à la famille ont reçu une aide entre 18 et 21 ans, c’est-à-dire après la fin de la tutelle. En tout, 917 de ces jeunes ont reçu une aide en 2017.
- La majorité des élèves manitobains de 9<sup>e</sup> année obtiennent un crédit de mathématiques (88 %) et un crédit d’English Language Arts (90 %) à la fin de l’année scolaire. 93 % et 94 %

des élèves non autochtones et 69 % et 74 % des élèves autochtones, respectivement, obtiennent ces crédits.

- Les notes moyennes obtenues aux examens provinciaux du Manitoba par les élèves de 12<sup>e</sup> année sont restées stables au cours des dix dernières années : entre 50 % et 60 % pour les mathématiques appliquées ou les mathématiques au quotidien, entre 60 % et 70 % pour les mathématiques pré-calcul, entre 60 %-70 % pour la langue. La note moyenne est légèrement plus élevée pour le français dans les programmes français et d’immersion.
- En 2015, aux examens PISA (le Programme international pour le suivi des acquis des élèves [PISA] de l’Organisation de coopération et de développement économiques [OCDE]), 83 % des élèves de 15 ans du Manitoba avaient le niveau de base en science, comparé à 89 % au Canada et 79 % dans tous les pays de l’OCDE.
  - Aux examens PISA, les jeunes du Manitoba ont obtenu de meilleurs résultats en maîtrise de la lecture que la moyenne des pays de l’OCDE, mais de moins bons résultats que la moyenne canadienne. Les résultats étaient meilleurs chez les filles que chez les garçons.
  - Aux examens PISA, les jeunes du Manitoba ont obtenu des résultats moins bons en maîtrise des mathématiques que la moyenne des pays de l’OCDE et la moyenne canadienne. Les résultats des filles et des garçons étaient semblables.
- En 2016, 78 % des élèves du Manitoba ont terminé leurs études secondaires « en temps voulu » (dans les quatre ans qui ont suivi leur entrée en 9<sup>e</sup> année); ce chiffre était constitué de 81 % des filles, 76 % des garçons, 86 % des élèves non autochtones et 48 % des élèves autochtones.
- En 2014-15, presque 40 000 jeunes manitobains de moins de 25 ans (57 % de jeunes femmes et 43 % de jeunes hommes) étaient inscrits dans un établissement postsecondaire.
  - Au cours des dix dernières années, les inscriptions ont augmenté de 26 % pour les jeunes femmes et de 24 % pour les jeunes hommes.
- Plus de la moitié des jeunes manitobains des Premières nations de 12 à 17 ans comprennent ou parlent une langue des Premières nations.
- La plupart des élèves manitobains de la 9<sup>e</sup> à la 12<sup>e</sup> année ont un sentiment d’appartenance à l’école (84 %) et ont au moins un ami ou une amie proche (94 %).
  - La plupart estiment que les adultes de la communauté scolaire sont bienveillants à leur égard et dignes de confiance (75 %-83 %), mais ils sont moins nombreux (64 %) à dire qu’ils s’adresseraient à une conseillère ou un conseiller, ou à un autre adulte, s’ils avaient besoin d’aide.
- Environ la moitié des jeunes manitobains de 15 à 24 ans sont satisfaits de la communication qu’ils ont établie avec leurs amis ou les membres de leur famille. Les chiffres sont semblables parmi les jeunes hommes (46 %) et les jeunes femmes (48 %).
- Au Manitoba, les deux tiers (66 %) des jeunes des Premières nations âgés de 12 à 17 ans participent à des manifestations culturelles locales.
- Un jeune manitobain de 15 à 24 ans sur deux (47 %) et quatre jeunes manitobaines du même âge sur cinq (78 %) font du bénévolat, ce qui est semblable à l’ensemble du Canada pour les garçons et plus élevé pour les filles.
- Le taux d’emploi chez les jeunes manitobains âgés de 15 à 19 ans a décliné régulièrement au cours de la dernière décennie, aussi bien pour les filles que pour les garçons (de 53 % à 40 % pour les garçons, de 55 % à 46 % pour les filles). Pour ce qui est des personnes de 17 à 24 ans au Manitoba, 64 % des hommes et 49 % des femmes avaient un emploi à plein

temps, ces taux ayant décliné régulièrement au cours des quatre dernières décennies, au début desquelles ils étaient de 82 % et 62 % respectivement.

- Dans les dix dernières années, le taux de criminalité chez les jeunes du Manitoba a décliné, comme chez les jeunes du Canada dans son ensemble, le taux de criminalité au Manitoba (4362 pour 100 000) étant deux fois plus élevé que celui du Canada. Le taux d'emprisonnement parmi les jeunes manitobains de 12 à 17 ans est quatre fois plus élevé que celui du Canada dans son ensemble.

## **Conclusion**

Ce rapport sur la situation des enfants et des jeunes du Manitoba donne des renseignements exhaustifs sur les progrès accomplis par notre province au cours des dix dernières années et plus en vue d'améliorer la vie de nos jeunes concitoyens. Les priorités interministérielles cernées récemment par le Comité ministériel pour Enfants en santé Manitoba sont confirmées par de nombreuses preuves et de nombreuses données. Ces priorités sont : vérité et réconciliation, développement de la jeune enfance, santé mentale des enfants et des jeunes, littératie et numératie, enfants pris en charge et transitions pour les jeunes vulnérables. Les indicateurs utilisés dans ce rapport peuvent servir de bases de référence et de points de repère pour les initiatives futures et pour permettre de continuer à mesurer les résultats, afin de mettre en pratique l'engagement du gouvernement provincial à être la province canadienne qui s'est le plus améliorée.

## Chapter 1. Introduction

Each day we face a great responsibility and an exciting opportunity to shape well-being and health of children and youth in Manitoba. Our quality of life depends on our commitment to develop a nurturing environment for our young people in their families, preschools, schools, and communities. Manitoba's children are developing into the people who will grow our food, build our cities, teach our next generation, and support us as we grow older.

### 1.1 Healthy Child and Youth Development

This report uses a broad definition of health that goes beyond illness or disease. It is also based on the consensus that a child's opportunity for lifelong health, well-being, and success is largely determined by his or her early development.<sup>1</sup> Healthy child and youth development is a complex physical, emotional and social process involving interactions between a child's genetics, family interactions, and the wider social environment.<sup>2</sup> Healthy communities and healthy families are crucial components of healthy child development. Although people can respond to positive influences during any stage of development, early childhood is particularly sensitive to influence, and early investments are our most efficient use of resources.<sup>3</sup>

Healthy child development can be described in terms of both risk and protective factors. A risk factor is a characteristic, experience, or event that is associated with an increase in the likelihood of a negative outcome that one might want to prevent.<sup>4,5</sup> A protective factor is associated with a decrease in the likelihood of a negative outcome or with an increase in the likelihood of a positive outcome.<sup>6</sup> Risk and protective factors can be found in children, families, and the larger community.<sup>7</sup> Vulnerability refers to an individual or group's susceptibility to negative outcomes when exposed to risks. Vulnerability is reduced through individual and social protective factors, which provide resources and strengthen abilities to cope with stressful circumstances. Families, preschools, schools, communities, and government all have a role in working to reduce risks and enhance protective factors in Manitoba's children, families, and communities.

### 1.2 Healthy Child Manitoba Strategy

Manitoba's Healthy Child Committee of Cabinet is unique as the only cross-departmental cabinet committee in Canada dedicated to improving the well-being of children, youth, their families and communities, as guided by the Healthy Child Manitoba Strategy (2000) and the Healthy Child Manitoba Act (2007). Established in 2000, HCCC was built on the horizontal, cross-departmental model of the Children and Youth Secretariat (1994-2000), which innovated, implemented and evaluated child-centred policy approaches (prenatal to adulthood). Since 2000, HCCC and its secretariat, the Healthy Child Manitoba Office, have continued this long-term, whole-of-government policy approach to children and youth. Under the *Healthy Child Manitoba Act*, at least once every 5 years, the Healthy Child Manitoba Office are directed to prepare a report on the status of Manitoba's children and youth in relation to achieving the outcomes of the Healthy Child Manitoba Strategy.

### 1.3 Report on Manitoba's Children and Youth

In the first chapter of this report, we begin by describing Manitoba's children and youth and their families. The report is then organized by four stages of child and youth development, each comprising a chapter of the report:

- the prenatal period
- early childhood (birth to age 5 years)
- middle childhood (ages 6 to 12/14 years)
- youth (ages 13/15 to 19 years)

The foundation for healthy child and youth development is reflected in the four outcome goals of the *Healthy Child Manitoba Act*. For each of the four stages of development above, the health and well-being of Manitoba's children and youth will be described (age-appropriately) for each of the four Healthy Child Manitoba outcome goals:

- physically and emotionally healthy
- safe and secure
- successful at learning
- socially engaged and responsible

Each chapter of this report discusses key indicators that can help us learn how Manitoba's children and youth are doing in each of these stages and for each of the four outcomes. When possible, indicators are presented across several years, to show trends over time. In addition, comparisons with Canada are shown (where available), as well as by sex, socioeconomic status, region, and ethnicity, when such data were available. The key indicators, including trends and comparisons, can help guide policy and action, in both government and community.

### 1.4 Guiding Principles for the 2017 Healthy Child Manitoba Child and Youth Report

The Healthy Child Manitoba Office (HCMO) 2017 Child and Youth Report Interdepartmental Working Group (CYRIWG) oversaw the development of this report. The CYRIWG is made up of experts from the Healthy Child Committee of Cabinet partner departments responsible for the health and well-being of Manitoba children, youth and families. The CYRIWG developed the following principles for the 2017 Healthy Child Manitoba Child and Youth Report:

Every child in Canada deserves a bright future. For their healthy development, all children need warm, nurturing environments, the opportunity to build secure attachments to their primary caregivers, and the feeling that they are part of a broader community that looks out for them. However, we know that many children do not receive this good start for a variety of reasons. As a result, throughout their lives they are more likely to draw upon the resources of systems such as healthcare, child welfare, and criminal justice. <https://thephilanthropist.ca/2014/12/an-action-framework-for-children-and-youth-in-canada/> There is very strong evidence that investments in the well-being of children yield a significant financial return over time, and that strategies designed to prevent problems are far less expensive to implement than remedial responses later. (OECD, 2006 <https://www.oecd.org/education/skills-beyond-school/37376068.pdf>)

1. ***Ground the document in child development, while maintaining a holistic approach to the child:*** It is important to maintain a holistic approach to child development because the process is interactive and comprehensive. Children are not small adults, and the

determinants that impact their lives can only be understood within a child development framework.

2. **Recognize sensitive periods in the development of a child:** There are periods in development during which children may be particularly sensitive to their environment. During the early years, children's biological systems (brain connections, the stress response system, the immune system) get shaped by environmental influences. The early years set the stage for lifelong learning and health. Therefore, having healthy physical and social environments during the early years may be particularly important, and interventions may be particularly effective as positive interactions and experiences create the building blocks for healthy child development. Risks, opportunities and interventions will help or hinder children and youth, both in the present and in the future. The sensitive periods and pathways to healthy development may differ for girls and boys, and there may be cultural variations in the ways that developmental transitions are interpreted.
3. **Acknowledge that children are important as children:** Children play a role in shaping their own lives. They contribute to their families, their schools, and their communities. Strategies must target improving children's lives now just as much as they aim to improve their futures. Strategies must recognize children's rights as articulated in the United Nations Convention on the Rights of the Child.
4. **Adopt a population-based approach that recognizes the complexity and diversity of children's lives:** A population-based approach includes everyone. It has the potential to reach all children, youth and families, and still direct attention to the most vulnerable, the most at risk. A population-based approach can be used to develop a detailed picture of children and youth that recognizes their multifaceted, multidimensional lives.
5. **Define health broadly to include wellness issues:** The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. In building a well-rounded understanding of the health of children and youth, both negative and positive outcomes will be included.
6. **Focus on critical issues:** Critical (important, necessary, timely) issues drive policy development. A critical issue can be identified quantitatively (through data/statistics) or qualitatively (public opinion, media, etc.). A focus on critical issues ensures that the information has the greatest possible impact, and requires that adequate attention be given to the most vulnerable children.
7. **Build on and foster awareness of Canada's and Manitoba's regional, ethnic, linguistic, cultural and religious diversity:** The population of Canada and the province of Manitoba in particular is increasingly diverse. Strategies to improve and promote health and well-being of children and youth must be flexible and responsive to community-level needs.
8. **Focus on prevention and health promotion:** Primary prevention seeks to avoid the onset of disease by eliminating or, at least, minimizing environmental factors and unhealthy behaviours that increase the risk of death, illness, and injuries. Health promotion creates the environment whereby individuals are able to reach their highest potential for health.

Strategies must include how one would like things to be in the future, reducing disease and setting goals for the promotion of health.

9. **Recognize major changes that have occurred in systems that support children and families:** The restructuring of health care, education and social systems has changed the way that care, education, social, and health services are provided. Statistics must be interpreted in light of these changes and strategies must be revisited and revised.
10. **Identify important issues even where available data are incomplete at this time:** The Precautionary Principle urges action in the best interests of children based on the information available at a given point in time. For example, in regard to widely distributed environmental toxins and toxicants, to wait for absolute and conclusive research can potentially put a generation of children at unnecessary risk.
11. **Recognize the disparities that exist for children and youth in Canada and within Manitoba:** Data needs to be presented in such a way that the disparities within Canada and Manitoba are made visible. Disparities may be regional or economic; they may be related to ethnicity, disability status or gender.
12. **Address present life quality and determine the desired future state:** Recognize that the determinants of health and children's circumstance influence the life/developmental trajectory they experience. Strategies must include how one would like things to be at some future time, addressing not only disease reduction but also setting goals for the promotion of health. Address the important considerations related to transition to adulthood.
13. **Indigenous Children and Youth in Manitoba:** Throughout this report, data reflecting Indigenous (First Nations, Métis and Inuit) children and youth outcomes may be presented separately from the rest of Manitoba's data. This is done out of respect for the unique history of Indigenous Peoples in Manitoba, and to acknowledge that intergenerational trauma continues to have effects on the youngest generations, leaving a legacy that affects language, culture, education, spirituality, and many other aspects of life within the Indigenous community. Some indicators in this report may reflect the impacts, while others demonstrate strengths.

## 1.5 Connections with Governmental Priority

### 1.5.1 The Path to Reconciliation Act

On June 2, 2015, the Truth and Reconciliation Commission of Canada (TRC) released its report, *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*,<sup>8</sup> which included 94 Calls to Action. A final report was released on December 15, 2015. Following the release of the TRC's final report, the Manitoba Government unanimously ratified *The Path to Reconciliation Act* which came into force on March 15, 2016. The Act was the first reconciliation legislation in Canada.

### 1.5.2 Reconciliation Definition

The TRC defined reconciliation as,



“...the ongoing process of establishing and maintaining mutually respectful relationships between Indigenous and non-Indigenous peoples in order to build trust, affirm historical agreements, address healing and create a more equitable and inclusive society.”

This is the definition adopted by the Manitoba Government in the Act.

### 1.5.3 Guiding Principles

To advance reconciliation, the Manitoba Government is guided by the following principles:

- **Respect:** Reconciliation is founded on respect for Indigenous nations and Indigenous peoples. Respect is based on awareness and acknowledgement of the history of Indigenous peoples and appreciation of their languages, cultures, practices and legal traditions.
- **Engagement:** Reconciliation is founded on engagement with Indigenous nations and Indigenous peoples.
- **Understanding:** Reconciliation is fostered by striving for a deeper understanding of the historical and current relationships between Indigenous and non-Indigenous peoples and the hopes and aspirations of Indigenous nations and Indigenous peoples.
- **Action:** Reconciliation is furthered by concrete and constructive action that improves the present and future relationships between Indigenous and non-Indigenous peoples.

### 1.5.4 Minister’s Role

The Minister of Indigenous and Northern Relations was assigned responsibility for reconciliation and is responsible for leading the government’s participation in the reconciliation process. As a member of Executive Council, the Minister:

- makes recommendations to Cabinet about measures to advance reconciliation
- promotes initiatives to advance reconciliation across all sectors of society including interdepartmental, intergovernmental, corporate and community initiatives
- promotes recognition of the contributions of Indigenous peoples to the founding of Manitoba
- guides the development of a strategy for reconciliation and
- makes recommendations to the government about financial priorities and resource allocations related to reconciliation on an across-government basis.

Each member of Executive Council is also responsible for promoting measures to advance reconciliation through the work of his or her department and across government.

### 1.5.5 Reconciliation Strategy

The government is working on an engagement strategy to seek feedback on a reconciliation strategy with Indigenous leaders.

### 1.5.6 *The Path to Reconciliation Act* Annual Progress Report

*The Path to Reconciliation Act* establishes a transparent mechanism to monitor and evaluate the measures taken by the Manitoba Government, including the measures taken to engage Indigenous nations and peoples in the process. The first report was tabled June 2016 in the

Legislative Assembly and translated into Cree, Dakota, Dene, Inuktitut, Michif, Ojibway and Ojibway-Cree. It is available to any person who wants a copy.

Working with many partner organizations, the government is taking action in the following areas:

**Addressing Legacies:** Manitoba is striving to address the disparity between Indigenous and non-Indigenous peoples in Manitoba's social, political and economic systems and institutions. The provincial government has partnered with many different service providers and organizations to address these gaps in the following areas:

- a. Caring for Children and Families
- b. Improving Health Outcomes
- c. Supporting Restorative Justice
- d. Supporting Indigenous Students and their Families in Education
- e. Delivering Training and Supporting Employment Opportunities

**Reconciling for the Future:** The Manitoba Government's efforts toward reconciliation are far from over. The provincial government is committed to the development of a fulsome reconciliation strategy that is informed through engagement with Indigenous nations and Indigenous peoples. Reconciliation efforts began prior to provincial legislation and will continue through the development and release of the reconciliation strategy. Manitoba, in partnership with many other organizations, has been looking at the following areas toward reconciliation:

- a. Children and Families
- b. Language, Culture, and Heritage
- c. Education and Training
- d. Reconciling Relationships
- e. Recognition and Reconciliation of Aboriginal and Treaty Rights
- f. Land-Based Initiatives

Copies of the Annual Reports (starting in 2017) can be found on the Manitoba Government website (<http://www.gov.mb.ca/inr/reports-and-expenses/index.html>).

## 1.6 Summary

The health and well-being of children and youth in Manitoba is largely determined by early development. We all have a role to reduce risks and enhance protective factors in Manitoba's children, families and communities. Strong evidence shows that investments in the well-being of children yield a significant financial return.

In March 2016, Manitoba passed *The Path to Reconciliation Act* to advance reconciliation in Manitoba. The Act requires Manitoba to develop a reconciliation strategy that builds on meaningful engagement with Indigenous nations and people and all Manitobans.

This is the second legislated public report on the status of Manitoba's children and youth, required every 5 years, under the *Healthy Child Manitoba Act*. The report is organized by four stages of child and youth development (prenatal, early childhood, middle childhood, youth), along with the four outcome goals of the Healthy Child Manitoba Strategy (physical and

emotional health, safety and security, success at learning, social engagement and responsibility).

Each chapter discusses key indicators in each stage for each outcome. Where possible, trends over time, and comparisons with Canada, and by gender, socioeconomic status, region, and ethnicity are included. The purpose of the report is to provide descriptive data to inform Manitobans about progress over time and priorities for the future.

## Chapter 2. Who Are Manitoba's Children and Youth?

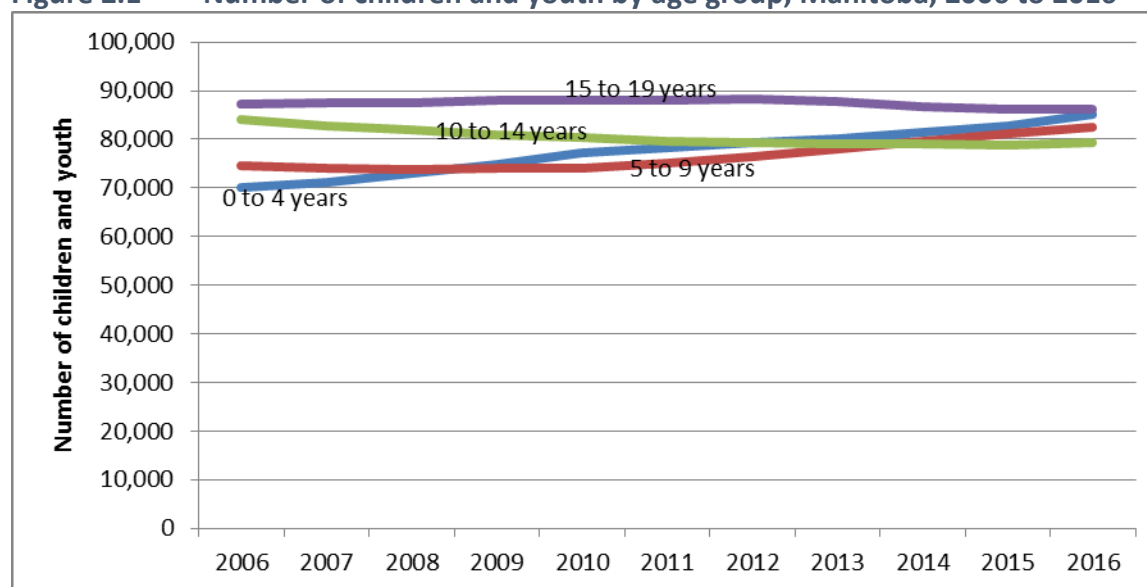
Children and youth represent a significant proportion of the population of Manitoba. In this chapter, we describe the characteristics of Manitoba's children and youth (usually up to age 18 or 19 years, depending on the data source) and their families. We examine things like the birth rate, family structure, and economic security. Manitoba's families are diverse with particular needs depending on their geographic location, ethno cultural and linguistic identity, and family structure. Manitoba's children and youth also have varying degrees of social and economic security, as seen in rates of low income, core housing need, and food insecurity.

An ethno cultural community or group is defined by the shared characteristics unique to, and recognized by, that group. This includes characteristics such as cultural traditions, ancestry, language, national identity, country of origin and/or physical traits (provided by the Manitoba Multiculturalism Secretariat).

### 2.1 The Number of Children and Youth in Manitoba

In 2016, there were over 335,000 children and youth ages 0 to 19 in Manitoba. The number of children and youth is increasing. Between 2006 and 2016, the number of children ages 0 to 4 increased by 21% and the number of children ages 5 to 9 increased by 11%. The number of children and youth 10 to 14 years and 15 to 19 years decreased slightly. Overall, the number of children and youth ages 0 to 19 increased by 6% (Figure 2.1). In 2015, 56% of children 0 to 19 lived in urban centres and 44% in rural Manitoba, unchanged from 2012.<sup>9</sup>

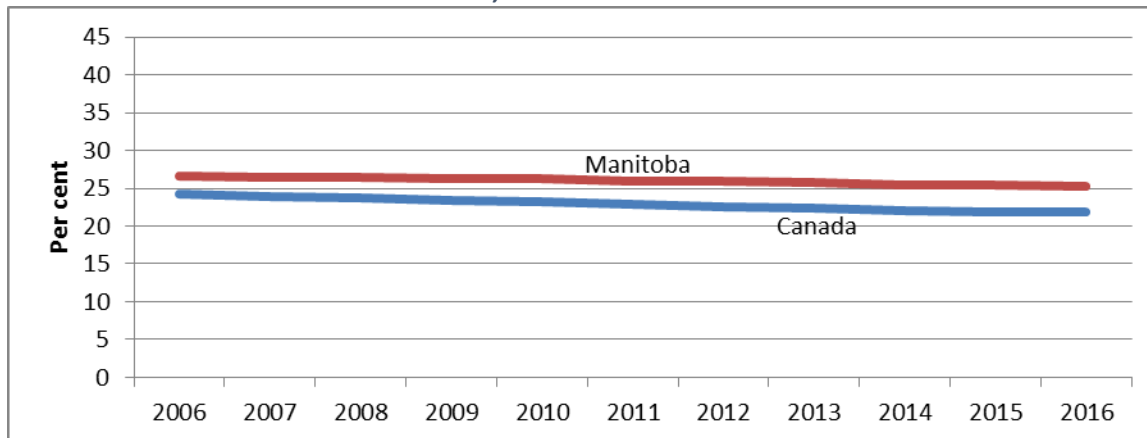
**Figure 2.1** Number of children and youth by age group, Manitoba, 2006 to 2016



Source: Statistics Canada. Table 051-0001 - Estimates of population, by age group and sex for July 1, Canada, provinces and territories, annual (persons unless otherwise noted) <http://www5.statcan.gc.ca/cansim/a26?id=510001> (accessed: August 07, 2017)

Children and youth make up over one-quarter (25.3%) of Manitoba's population. In Canada overall, children and youth make up 22% of the population (Figure 2.2). Therefore, Manitoba has a higher proportion of children and youth than Canada overall. The proportion of Manitoba's population that are children and youth (under 20 years of age) has declined slightly, from 27% in 2006 to 25% in 2016 (Figure 2.2).

**Figure 2.2 Children and youth as a per cent of the total population, Manitoba and Canada, 2006 to 2016**

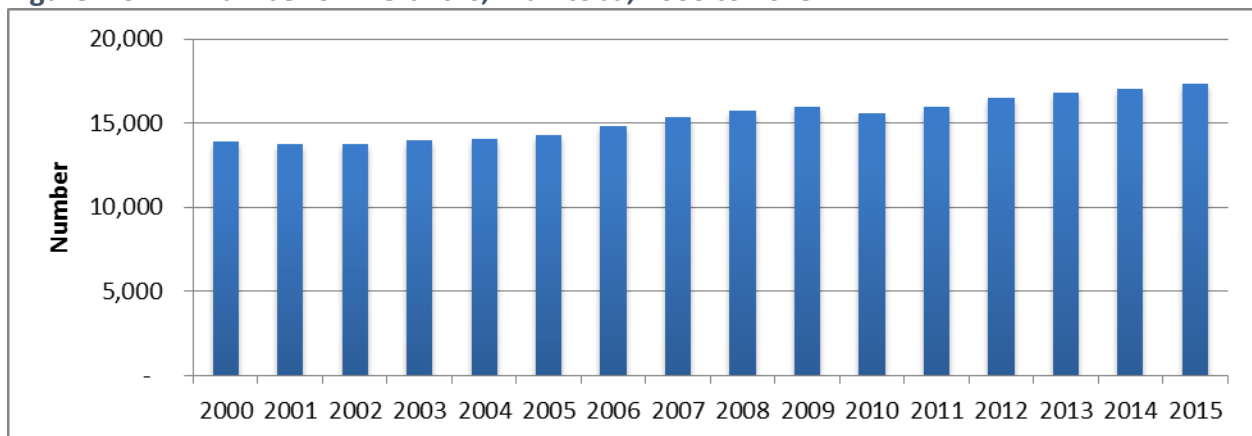


Source: Statistics Canada. Table 051-0001: Estimates of population, by age group and sex for July 1, Canada, provinces and territories, annual (persons unless otherwise noted). Available from: <http://www5.statcan.gc.ca/cansim/a26?id=510001> (Accessed April 20, 2017)

## 2.2 Births and Birth Rate

Although the proportion of children in Manitoba is declining, the number of children has been increasing (Figure 2.3) and is expected to increase in the years to come, particularly for the preschool age group. Population projections suggest that, between 2013 and 2020, Manitoba’s population under the age of five will increase by almost 9,000, or 11%.<sup>9</sup>

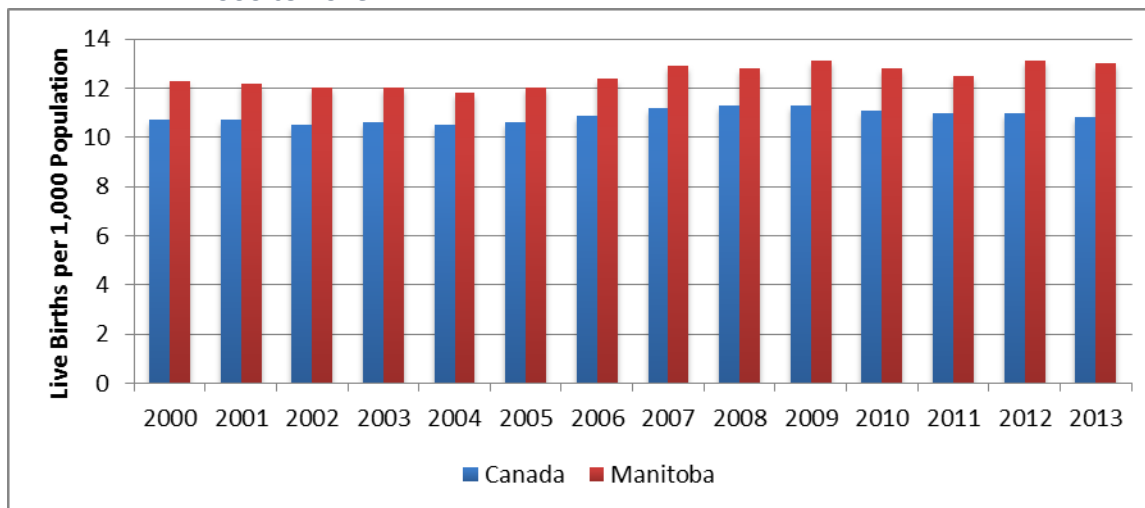
**Figure 2.3 Number of live births, Manitoba, 2000 to 2015**



Source: Statistics Canada. Table 051-0013: Estimates of births, by sex, Canada, provinces and territories, annual (persons). Available from: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510013&pattern=&stByVal=1&p1=1&p2=-1&tabMode=dataTable&csid=> (Accessed July 24, 2017)

The crude birth rate is the number of live births per 1,000 population. In Manitoba, the crude birth rate is rising. The crude birth rate in Manitoba has been consistently above the Canadian average (Figure 2.4). This is contributing to the increase in the population of children and youth in Manitoba.

**Figure 2.4 Crude birth rate, live births per 1,000 population, Manitoba and Canada, 2000 to 2013**

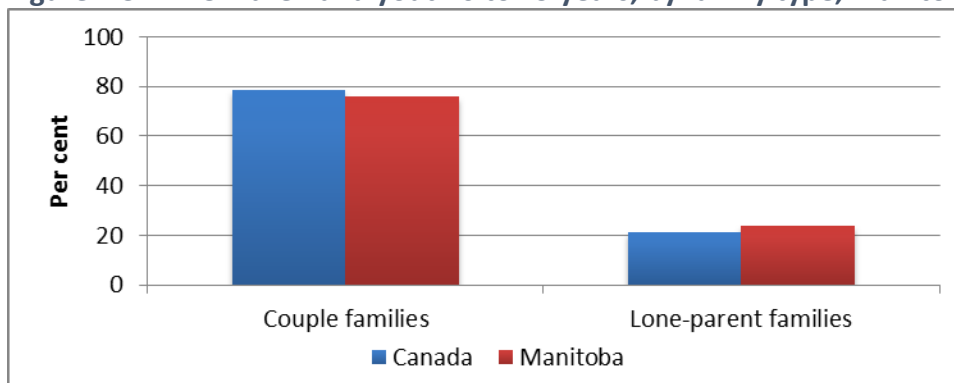


Source: Statistics Canada. Table 102-4505: Crude birth rate, age-specific and total fertility rates (live births), Canada, provinces and territories. Available from: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1024505> (Accessed September 24, 2017)

### 2.3 Family Structure and Income

In 2015, most Manitoba children and youth 0 to 19 years of age lived in two-parent families (76%). Approximately 24% of children and youth in Manitoba lived with one parent (Figure 2.5). That was slightly more than the proportion of children and youth living with one parent in Canada (21%).

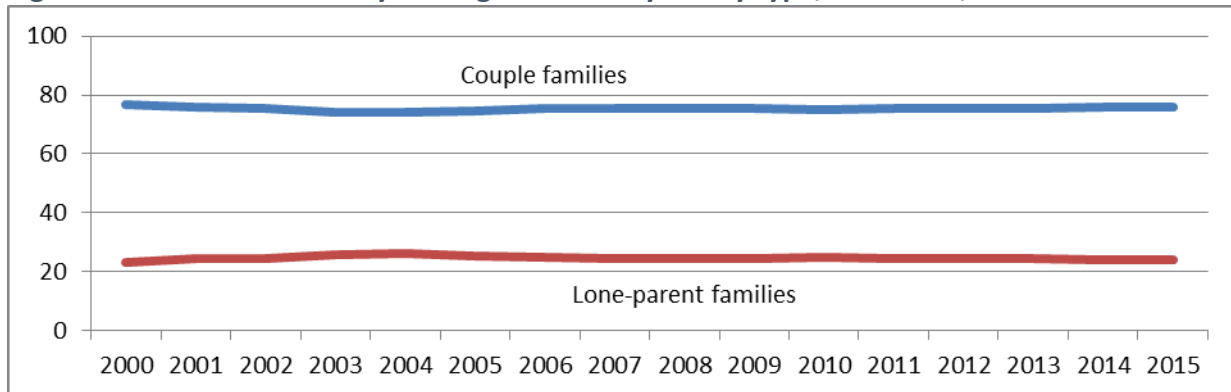
**Figure 2.5 Children and youth 0 to 19 years, by family type, Manitoba and Canada, 2015**



Source: Statistics Canada. Table 111-0010: Characteristics of families, tax filers and dependents by age groups and census family type, annual (number unless otherwise noted). Available from: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1110010&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=> (Accessed July 24, 2017)

The proportion of all children and youth living with two parents has remained stable since 2000. The proportion of all children living in lone-parent families has also remained virtually unchanged since 2000 (Figure 2.6).

**Figure 2.6 Children and youth ages 0 to 19 by family type, Manitoba, 2000 to 2015**

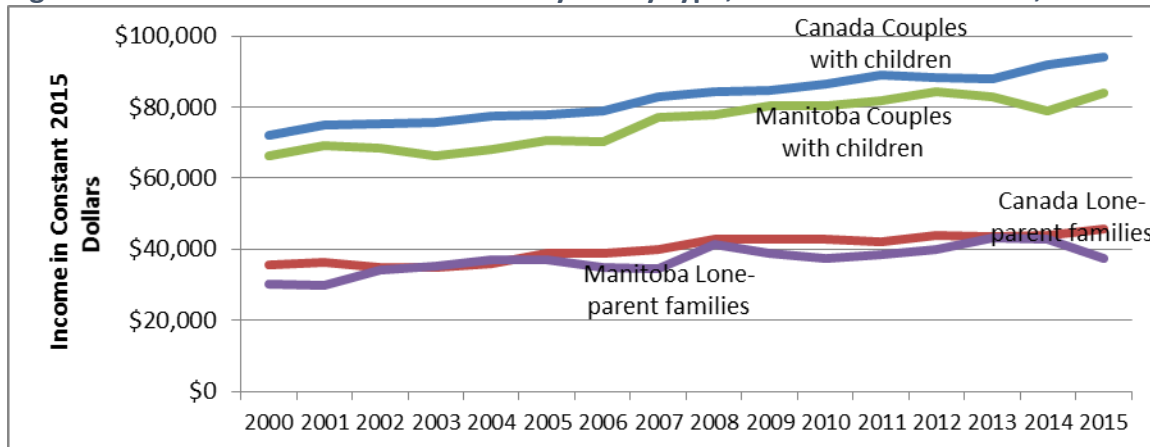


Source: Statistics Canada. Table 111-0010: Characteristics of families, tax filers and dependents by age groups and census family type, annual (number unless otherwise noted). Available from: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1110010&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=> (Accessed July 24, 2017)

Older children and youth are more likely to live with one parent in Manitoba; 26% of teenagers 15 to 19 years of age live with one parent compared to 22% of infants and preschoolers under age 5.<sup>10</sup>

In both Manitoba and Canada, lone-parent families have lower average family incomes than two-parent families (Figure 2.7). Average (after-tax) incomes have risen for both couple and lone-parent families in Canada and Manitoba between 2000 and 2015, but the per cent increase has been greater for couple families in both cases. Both couple families and lone-parent families with children in Manitoba have lower average family incomes than families in Canada overall (Figure 2.7).

**Figure 2.7 Median after-tax income by family type, Manitoba and Canada, 2000 to 2015**



Source: Statistics Canada. Table 206-0011: Market income, government transfers, total income, income tax and after-tax income, by economic family type, Canada, provinces and selected census metropolitan areas (CMAs), annual. Available from: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=2060011&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=> (Accessed July 24, 2017)

## 2.4 Ethnocultural and Linguistic Identity

The children and youth of Manitoba are a diverse group with regards to their culture, ethnicity, identity and languages spoken.

An ethnocultural community or group is defined by the shared characteristics unique to, and recognized by, that group. This includes characteristics such as cultural traditions, ancestry, language, national identity, country of origin and/or physical traits.

To the extent that religion is inextricably linked to a group's racial or cultural identity, it can also be recognized as a defining characteristic. In some cases, a group may view its common origin as pan-national, or it may be based on geographic region of origin. These characteristics are the basis on which, generally speaking, one group culturally distinguishes itself from another.

The term ethnocultural is sometimes used for groups that identify as ethnoracial or racialized. Some use these terms instead of ethnocultural, to make it clear that groups distinguishable by a visible characteristic (often skin colour, but also other shared physical traits) are more vulnerable to discrimination and disadvantage.

Presence of disadvantage is reflected in the barriers some groups face to full and equal participation in Canadian society. They may be disadvantaged socially, politically, educationally, as well as economically. For example, members of some ethnocultural and ethnoracial communities experience discrimination, unequal access to services (for example, due to language or cultural barriers), high levels of poverty, and greater vulnerability to violence (for example, the target of hate crimes). This disadvantage sometimes results in substandard living conditions in neighbourhoods that have inadequate housing, high crime rates, low educational achievement, and public health problems. Not all ethnocultural communities in Canada will face disadvantage, nor will ethnocultural communities experience exclusion in the same way.

Note: Canadian case law recognizes Indigenous (First Nations, Métis and Inuit) peoples as having a distinct status based on their unique historical, legal, and constitutional position in Canada. Indigenous people are not included in this definition of ethnocultural.

Multiculturalism Secretariat



## Indigenous Children and Youth

There are three groups of Indigenous peoples in Canada: First Nations, Métis and Inuit. Manitoba is located on the traditional lands and territories of the Cree, Dakota, Dene, Ojibway, and Oji-Cree, Métis and Inuit. Just over half of Indigenous people in Manitoba live in cities. Winnipeg, the capital of Manitoba, has the largest Indigenous population of any city in Canada.

Manitoba benefited from and continues to benefit from the historical relationships and treaties with Indigenous peoples and nations. However, since European contact, Indigenous people have been subject to a wide variety of human rights abuses which have left a legacy of educational, health and social disparities between Indigenous people and other Manitobans and Canadians.

The impacts of the legacy affected generations that followed, extended families and communities and continues to constrain Indigenous children's life chances. The disproportionate apprehension of Indigenous children by child and family services agencies, and the significant educational, income, health and social disparities between Indigenous and non-Indigenous children, youth and families can be explained in part as a result or legacy of the way that generations of Indigenous people were treated and the impact of colonial policies.

Many Canadians know little or nothing about the deep historical roots for these disparities. This lack of historical knowledge and context has serious consequences for First Nations, Métis and Inuit peoples and for Canada as a whole. For government, an absence of historical understanding means repeating historical mistakes and making poor public policy decisions. In the public realm, it reinforces racist attitudes and fuels distrust between Indigenous peoples and other Canadians. Non-Indigenous people have been taught to believe that Indigenous cultures and communities were inferior. These biased and invalid ideas led to generations of Canadians who held inaccurate stereotypes about Indigenous peoples and created unbalanced relationships in every sector of Canadian society.

Reconciliation will not be possible until the complex legacy is understood, acknowledged and addressed. Some of the damages done to Indigenous families, languages, education, and health may be perpetuated if existing approaches of government are not grounded in an understanding of Indigenous people. We must learn from the failure of colonial policies to ensure that mistakes made in the past are not repeated in the future.

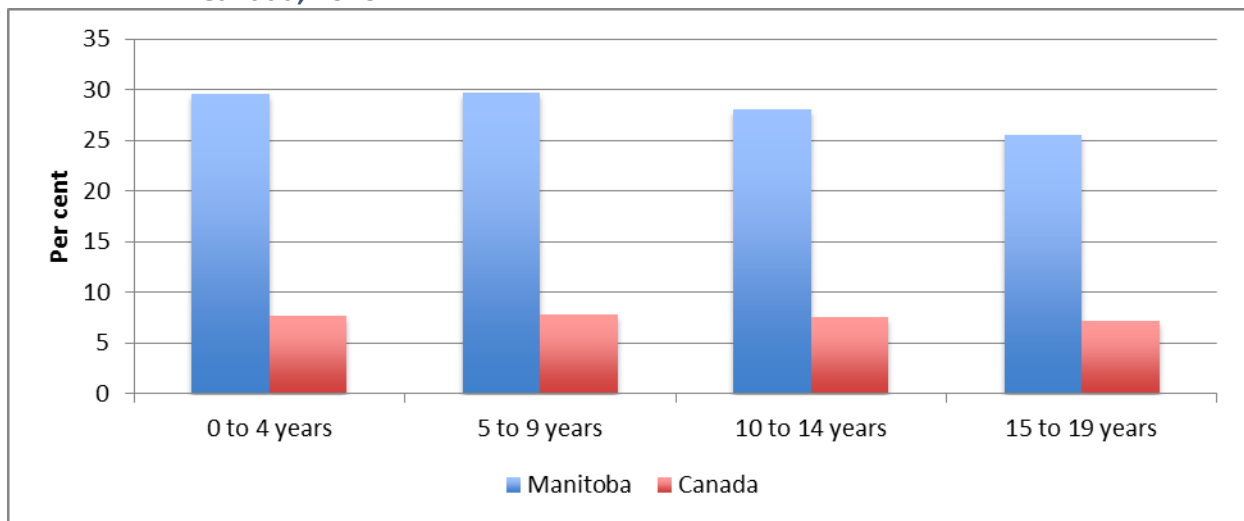
Reconciliation needs to consider "decolonization". Decolonization may be described as addressing the effects of colonization - as a way of doing things by building on understanding and respect for Indigenous peoples' knowledge, values and ways of life. Decolonization for government will mean exploring new approaches in relationships with Indigenous peoples and creating opportunities for Indigenous nations and peoples to reconnect with Indigenous languages and cultures and to close the enduring socioeconomic gaps between Indigenous and non-Indigenous peoples.

Department of Indigenous and Municipal Relations

Manitoba has a high percentage of Indigenous families and children, and this percentage continues to grow.

In 2016, over 90,000 children and youth aged 0 to 19 years identified, or their parents identifies that they were Indigenous. Indigenous children and youth under age 20 represent 28% of all Manitoba children and youth in that age group. The proportion is higher for young children under 5, where 30% of Manitoba's young children are identified as Indigenous. That compares to only 8% in Canada overall. Of all 5- to 9-year-old Manitobans, 30% are Indigenous, as are 28% of 10- to 14-year-olds and 26% of 15- to 19-year-olds (Figure 2.8).

**Figure 2.8 Indigenous children as a proportion of all children, by age group, Manitoba and Canada, 2016**



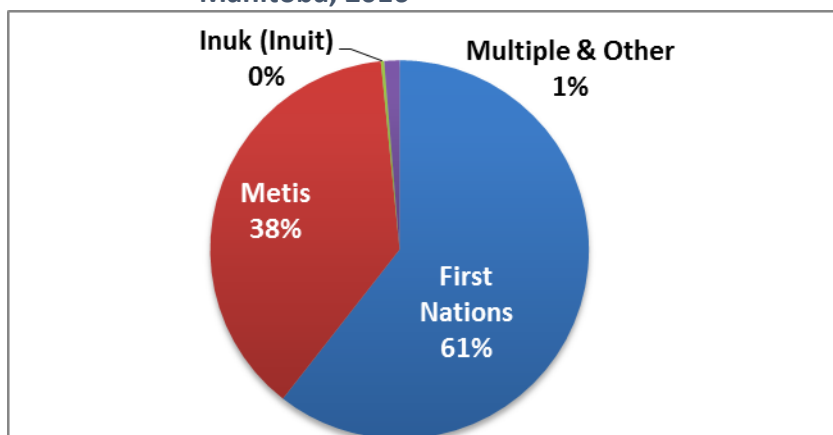
Source: Statistics Canada. Catalogue Number 98-400-X2016155. 2016 Census. Available from: <http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=01&GK=1&GRP=1&PID=110588&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=122&VID=0&VNAMEE=&VNAMEF=> (Accessed October 26, 2017)

Notes: The estimates represent children/youth who self-identify or whose parents identify them as Indigenous. The estimates associated with this variable are more affected than most by the incomplete enumeration of certain Indian reserves and Indian settlements in the Census of Population.

For more information on Indigenous variables, including information on their classifications, the questions from which they are derived, data quality and their comparability with other sources of data, please refer to the Aboriginal Peoples Reference Guide, Census of Population, 2016 and the Aboriginal Peoples Technical Report, Census of Population, 2016.

Of Indigenous children and youth, 61% identify as First Nations, while 38% identify as Métis (either self- or parent-identified) (Figure 2.9).

**Figure 2.9 Métis and Indigenous children and youth ages 0 to 19 of age, by identity, Manitoba, 2016**

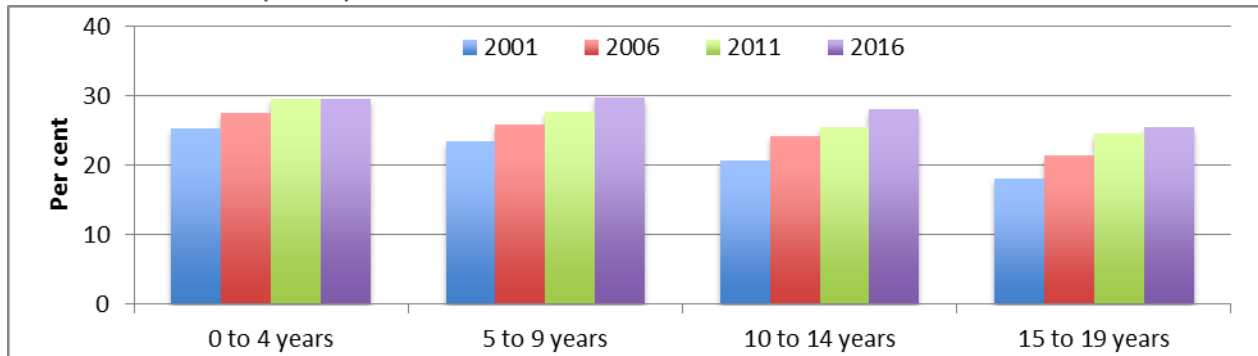


Source: Statistics Canada. Catalogue Number 98-400-X2016155. 2016 Census. Available from: <http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=01&GK=1&GRP=1&PID=110588&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=122&VID=0&VNAMEE=&VNAMEF=> (Accessed October 26, 2017)

Notes: The estimates represent children/youth who self-identify or whose parents identify them as Indigenous. The estimates associated with this variable are more affected than most by the incomplete enumeration of certain Indian reserves and Indian settlements in the Census of Population.

The number of Indigenous children and youth in Manitoba is growing. In 2001, there were approximately 68,500 Indigenous children and youth under age 20 in Manitoba.<sup>11</sup> In 2006, that number grew to just over 76,000, and in 2011, it grew again to over 83,000 and in 2016 to over 90,000 children and youth. The proportion of Indigenous children in Manitoba continues to grow among all age groups (Figure 2.10).

**Figure 2.10 Indigenous children as a proportion of all children, by age group, Manitoba, 2001, 2006, 2011 and 2016**



Source: Statistics Canada. Aboriginal Identity Population (3), Registered Indian Status (3), Age Groups (11B), Sex (3) and Area of Residence (7) for Population, for Canada, Provinces and Territories, 2001 Census - 20% Sample Data. Aboriginal Ancestry (10), Area of Residence (6), Age Groups (12) and Sex (3) for the Population of Canada, Provinces and Territories, 2006 Census - 20% Sample Data. Aboriginal Identity (8), Age Groups (20), Area of Residence: Inuit Nunangat (7) and Sex (3) for the Population in Private Households of Canada, Provinces and Territories, 2011 National Household Survey

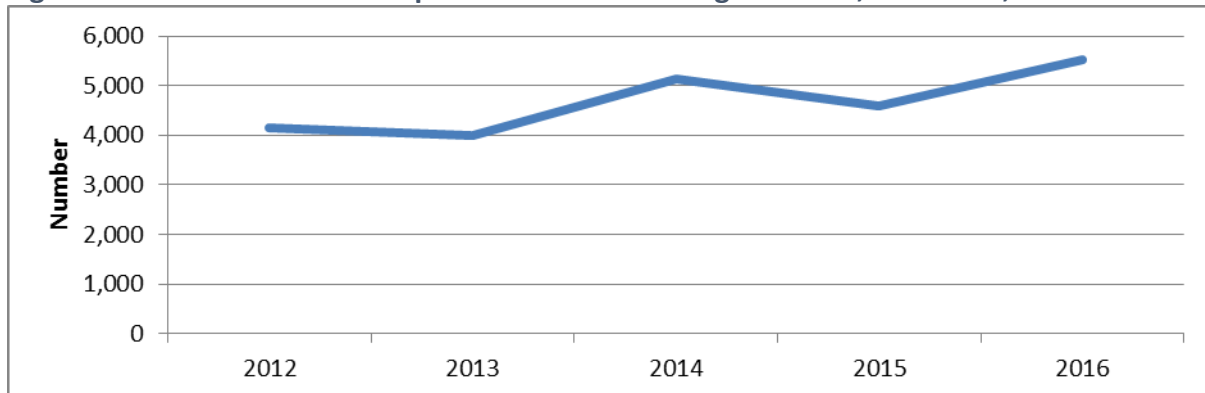
Statistics Canada. Catalogue Number 98-400-X2016155. 2016 Census. <http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=01&GK=1&GRP=1&PID=110588&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=122&VID=0&VNAMEE=&VNAMEF=> (Accessed October 26, 2017)

Notes: The estimates represent children/youth who self-identify or whose parents identify them as Indigenous. The estimates associated with this variable are more affected than most by the incomplete enumeration of certain Indian reserves and Indian settlements in the Census of Population.

### 2.4.1 Immigrant and Refugee Children and Youth

In 2016, 16,821 people who were born in other countries became permanent residents in Manitoba, of which 5,521 were children and youth ages 0 to 19. The number of children and youth who became permanent residents in Manitoba has been increasing since 2012. Compared to 2012, the number of children and youth who made Manitoba their permanent home increased by 33% (Figure 2.11).

**Figure 2.11 Number of new permanent residents ages 0 to 19, Manitoba, 2012 to 2016**

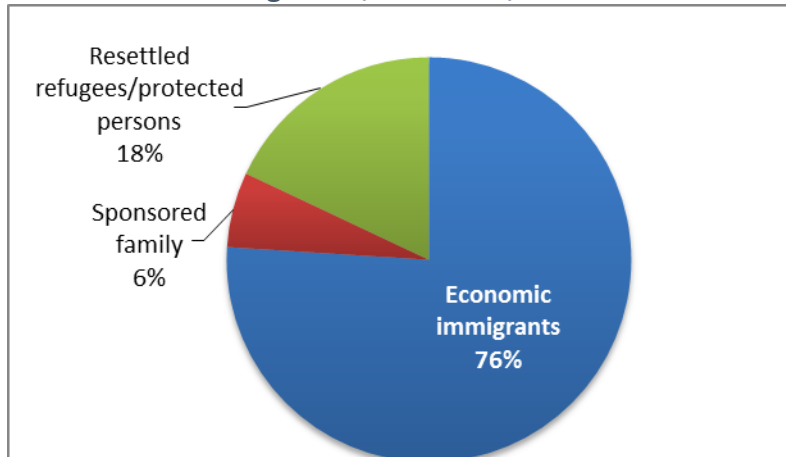


Source: Created by the Province of Manitoba using Immigration, Refugees, and Citizenship Canada (IRCC) Q2 2017 immigration data.

Among new permanent residents ages 0 to 19, from 2012 to 2016, 76% were economic immigrants, 6% were in a sponsored family and 18% were resettled refugees/protected persons

in Canada (Figure 2.12). Those proportions were different from those for adults 20 years and older. Among new permanent residents ages 20 and older, from 2012 to 2016, 73% were Economic immigrants, 16% were in a sponsored family and 11% were resettled refugees/protected persons in Canada.<sup>a</sup>

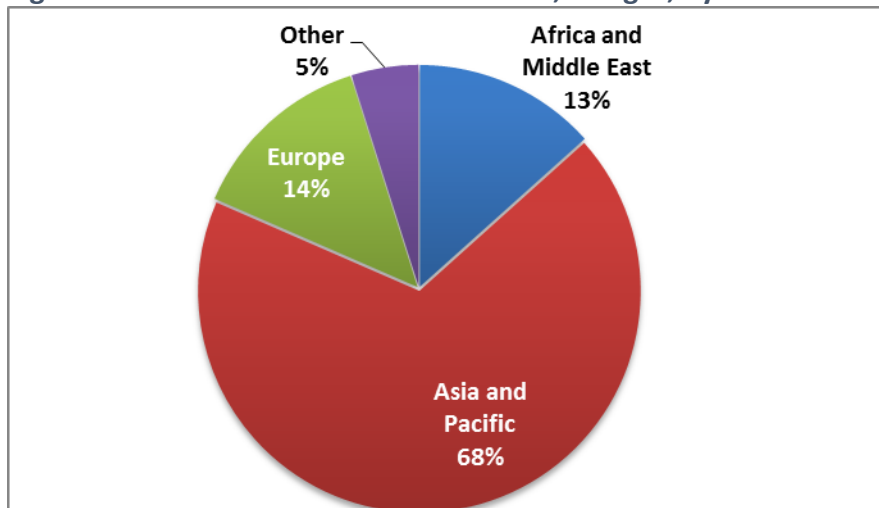
**Figure 2.12 Distribution of new permanent residents, youth ages 0 to 19, by category of immigration, Manitoba, 2012 to 2016**



Source: Created by the Province of Manitoba using IRCC Q2 2017 immigration data.  
 Note: Includes a very small number of permanent residents for whom age is recorded as “not stated.”

The majority of newcomers in Manitoba were from Asia and the Pacific (68%), followed by Europe (14%) and Africa/the Middle East (13%) (Figure 2.13).

**Figure 2.13 Distribution of newcomers, all ages, by source country, Manitoba, 2015**

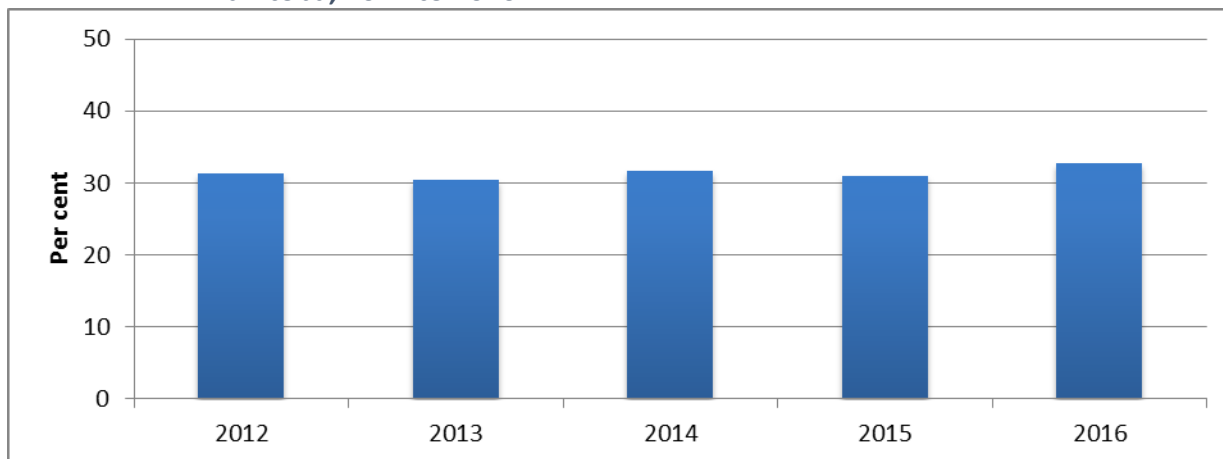


Source: Immigration, Refugees and Citizenship Canada. Facts & Figures 2015: Immigration Overview – Permanent Residents – Annual IRCC Updates.

Children and youth make up a considerable proportion of all new permanent residents in Manitoba. In 2016, 33% of new permanent residents in Manitoba were children and youth ages 0 to 19. That proportion has increased since 2012 when it was 31% (Figure 2.14).

<sup>a</sup> Based on analysis created by the Province of Manitoba using Immigration, Refugees, and Citizenship Canada (IRCC) Q2 2017 immigration data.

**Figure 2.14 Per cent of new permanent residents who are children and youth ages 0 to 19, Manitoba, 2012 to 2016**



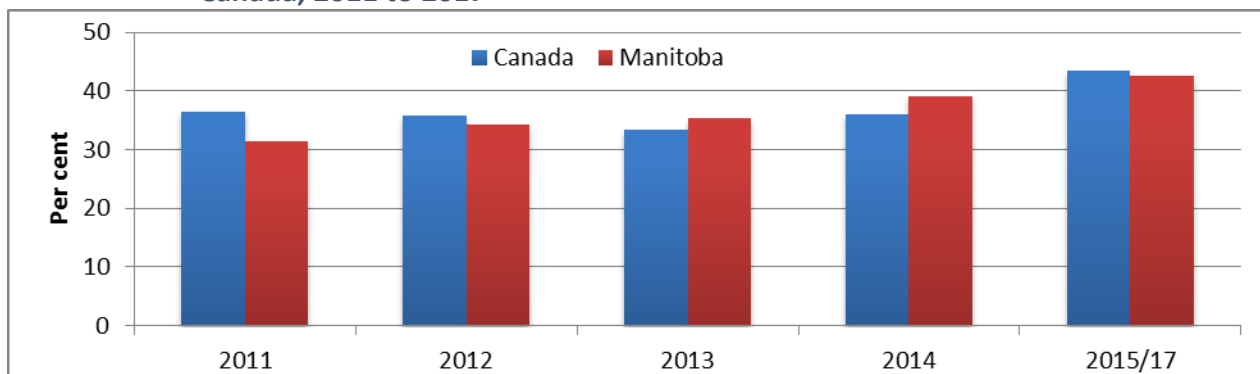
Source: Created by the Province of Manitoba using IRCC Q2 2017 immigration data.

Note: Includes a very small number of permanent residents for whom age is recorded as “not stated.”

Manitoba’s newcomers continue to be younger on average than newcomers in Canada overall. According to the 2011 Census, 25% of Manitoba’s newcomers (who arrived since 2006) were children under the age of 15, compared to 19% of Canada’s newcomers; 16% of Manitoba’s newcomers (who arrived since 2006) were youth 15 to 24 years compared to 15% of Canada’s newcomers.<sup>12</sup>

In 2015/17 (January 2015 to June 2017), 43% of the resettled refugees in Manitoba were under the age of 18, up from 32% in 2011 (Figure 2.15). For Canada those figures were 44% in 2015/17 and 36% in 2011.

**Figure 2.15 Per cent of resettled refugees who are under 18 years of age, Manitoba and Canada, 2011 to 2017**



Sources: For 2011 to 2014, IRCC, September 30, 2016 Data. For 2015/17, IRCC, June 30, 2017.

Note: 2015/17 refers to January 2015 to June 2017.

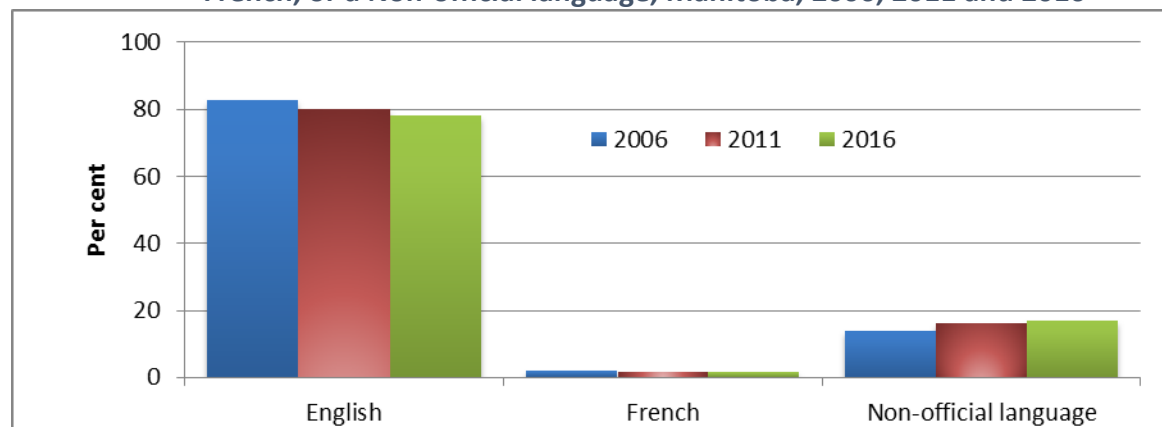
Between November 2015 and the end of June 2017 there were 1,740 Syrian refugees who resettled in Manitoba. Of them, 58% were under 18 compared to 49% in Canada overall.<sup>13</sup>

## 2.4.2 Language

In Manitoba, the proportion of children and youth ages 0 to 19 whose mother tongue was English in 2016 was 78.3%, down from 82.9% in 2006 and 79.9% in 2011 (Figure 2.16). The

proportion of children and youth whose mother tongue was French was 1.8% in 2016 a small decrease from 2006. The proportion of 0- to 19-year-olds whose mother tongue was a non-official language is increasing (Figure 2.16).

**Figure 2.16 Per cent of children and youth ages 0 to 19 whose mother tongue is English, French, or a Non-official language, Manitoba, 2006, 2011 and 2016<sup>14,15,16</sup>**



Sources: Statistics Canada. 2007. Population by mother tongue and age groups, 2006 counts, for Canada, provinces and territories, and census metropolitan areas and census agglomerations - 20% sample data (table). Language Highlight Tables. 2006 Census. Statistics Canada Catalogue no. 97-555-XWE2006002. Ottawa. Released December 4, 2007. <http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/hlt/97-555/T401-eng.cfm?Lang=E&T=401&GH=6&GF=46&SC=1&S=0&O=A>. (Accessed August 7, 2017)

Statistics Canada - 2011 Census. Catalogue Number 98-314-XCB2011026. <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/tbt-tt/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=1&DIM=0&FL=A&FREE=0&GC=0&GID=911114&GK=0&GRP=1&PID=102842&PRID=0&PTYPE=101955&S=0&SHOWALL=0&SUB=0&Temporal=2011&THEME=90&VID=0&VNAMEE=&VNAMEF=&D1=0&D2=0&D3=0&D4=0&D5=0&D6=0> (Accessed August 7, 2017).

Statistics Canada - 2016 Census. Catalogue Number 98-400-X2016046. <http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GK=0&GRP=1&PID=109662&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2016&THEME=118&VID=0&VNAMEE=&VNAMEF=> (Accessed September 15, 2017)

At the time of the 2016 Census, among the Manitoba population overall, the Anglophone population (English as a mother tongue) was 71.4%. The Francophone population (French as mother tongue) in Manitoba was 41,525, or 3.2% of the population (down from 3.9% in 2006 and 3.5% in 2011).<sup>14,15,16</sup>

In 2016, 2.4% of Manitobans reported that their mother tongue was an Indigenous language. Among 0- to 19-year-olds, 1.9% reported that their mother tongue was an Indigenous language.<sup>17</sup> In 2016, the top 4 Indigenous languages spoken at home were Cree, Ojibway, Oji-Cree and Dene.<sup>18</sup>

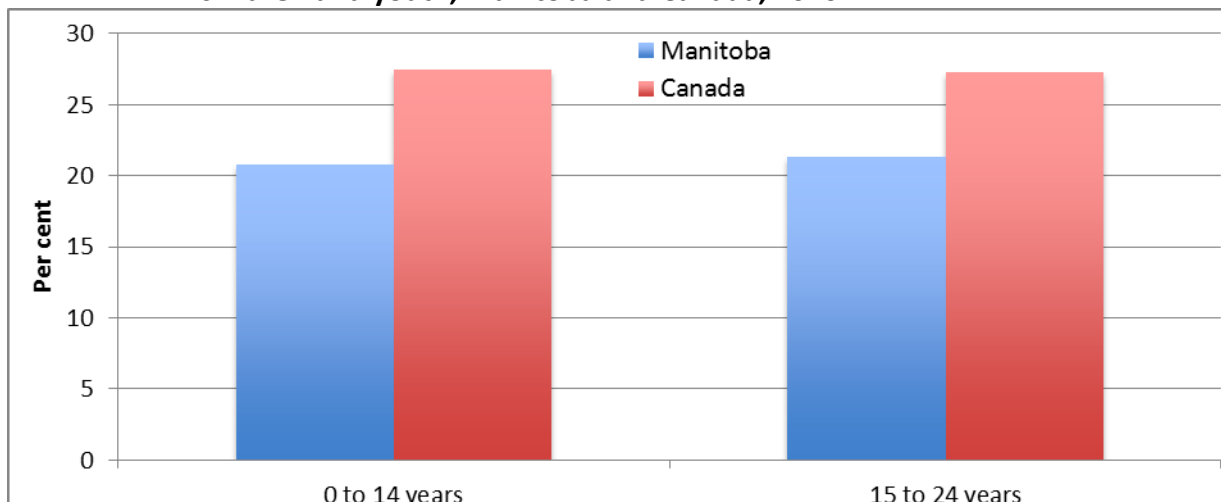
According to the 2016 Census, the most commonly spoken non-official languages in Manitoba are Tagalog (Filipino), German, Punjabi, Cree, Ojibway, Spanish and Mandarin.<sup>18</sup>

### 2.4.3 Children and Youth from Visible Minority Groups<sup>b</sup>

In 2016, 21% of all Manitoba children and youth under the age of 15 were from a visible minority group, as were 21% of 15- to 24-year-olds. The proportion of children and youth in Manitoba who are from a visible minority group is smaller than that for Canada overall (Figure 2.17).

<sup>b</sup> The Employment Equity Act defines visible minorities as ‘persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.’

**Figure 2.17 Visible minority children and youth as a per cent of the total population of children and youth, Manitoba and Canada, 2016**



Source: Statistics Canada - 2016 Census. Catalogue Number 98-400-X2016190. <http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GK=0&GRP=1&PID=110531&PRID.=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=120&VID=0&VNAMEE=&VNAMEF=> (Accessed October 27, 2017)

### **Multiculturalism in Manitoba**

Multiculturalism has long been at the heart of Manitoban society and diversity remains a fundamental characteristic of our identity. Manitoba is a welcoming and supportive home for people from around the world. The rich mosaic that is Manitoba is protected and promoted by the Manitoba Multiculturalism Act, whose tenets are put into practice by the Multiculturalism Secretariat and guided by community support. There are currently more than 300 ethnocultural groups in Manitoba representing 64 First Nations and over 150 countries and speak over 150 languages.

We continue to work toward inclusion and true inclusion means opportunity. The opportunity for all our citizens from all walks of life to learn, advance and contribute - together.

*Multiculturalism Secretariat*

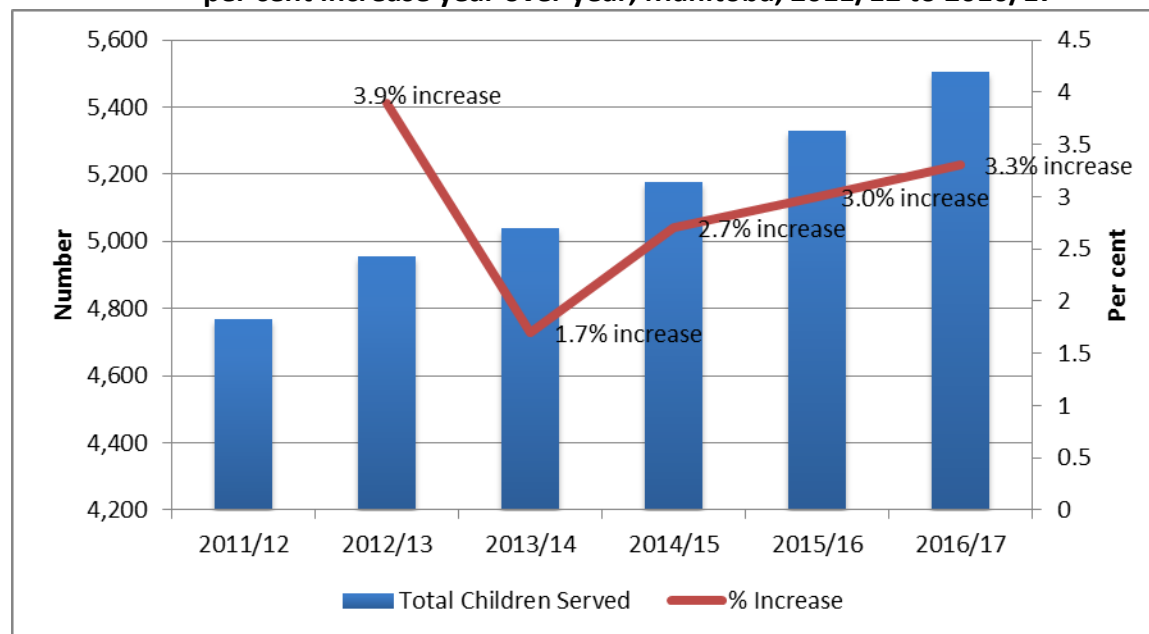
## **2.5 Children and Youth with Disabilities**

There is a lack of data in Manitoba and Canada on the incidence of disabilities among children and youth. Canadian children and youth with disabilities are a diverse group: some are Indigenous or come from other countries, some live in two-parent households and some live in lone-parent families. Some live in large cities, while other live in isolated communities. They come from a variety of cultural and faith backgrounds. Within a distinct type of disability, there are unique needs and abilities.

In Manitoba, Children’s disABILITY Services (CDS) is a voluntary program that supports families who are raising a child (or children) with developmental and lifelong physical disabilities, to meet some of the additional needs they may have. CDS offers a variety of resources and supports to parents and extended family members to assist them to care for their children at home in their own communities. Services and supports are intended to strengthen families and reduce stress so that costly out-of-home placements are prevented or delayed. Children’s DisABILITY Services provides families with a variety of supports that respond to their unique circumstances and the assessed needs of each child. In 2016/17, CDS provided funding and

support for the delivery of individualized services to 5,505 children and their families across the province. The number of children and families being served by this voluntary program has been steadily increasing over the past 5 years (Figure 2.18).

**Figure 2.18 Number of children served by the Children’s DisABILITY Services Program, and per cent increase year over year, Manitoba, 2011/12 to 2016/17**



Source: Manitoba Family Services. Annual Reports. 2011/12, 2012/13, 2013/14, 2014/15, 2015/16, 2016/17.  
[http://www.gov.mb.ca/fs/about/print,annual\\_reports.html](http://www.gov.mb.ca/fs/about/print,annual_reports.html)

In collaboration with the provincial departments of Health, Seniors and Active Living; Education and Training; and the Healthy Child Manitoba Office; CDS provides policy direction and financial support for the implementation of the Children’s Therapy Initiative (CTI), which includes children’s occupational therapy, physiotherapy, speech and language therapy and audiology services. CTI provides a coordinated approach to the delivery of therapy services so that services for children are maximized. Therapy services are delivered through the Regional Health Authorities, school divisions and service agencies. In 2016/17, CDS served an estimated 44,000 children across the province through their support to regional CTIs.

## 2.6 Children in Care

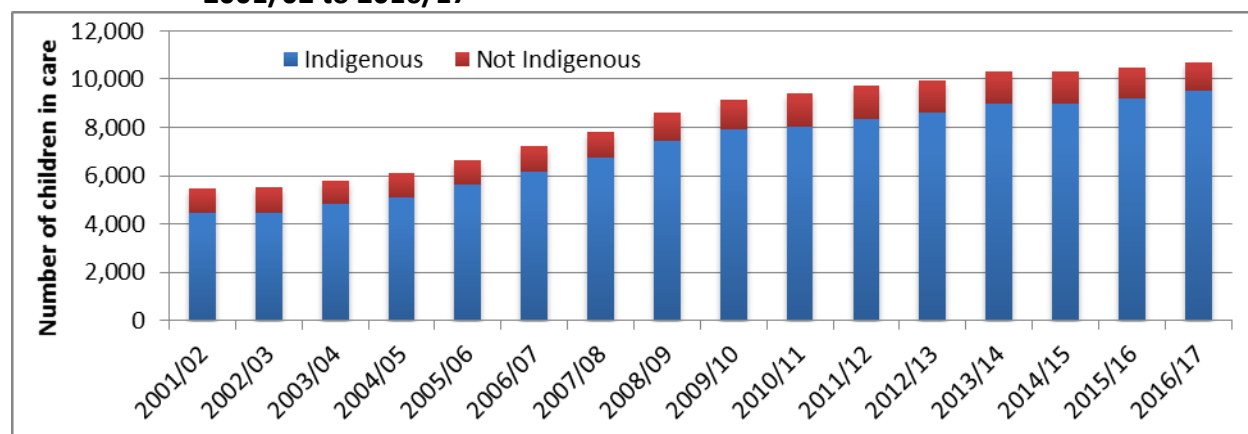
Children in care refers to children under the age of 18 who have been deemed in need of protection, requiring intervention, as determined by The Child and Family Services Act, or are voluntarily placed in care by agreement between the parent or guardian and child and family services agency. Children can come into care for a variety of reasons, including abuse and neglect. The issue of children in care in Manitoba is complex, with many driving factors. These include an overall increase in provincial population growth, high rates of teen pregnancy, households in core housing need, children with special medical needs, addictions, domestic violence, poverty and limited resources and capacity.



Many children and families receive services in their homes. Where children require out-of-home care, the goal is to reunite them with their families of origin when it is safe and appropriate to do so.

Both the absolute number of children in care in Manitoba (Figure 2.19) and the percentage of Manitoba children in care relative to the overall child population (from 1.9% in 2001/02 to 3.5% in 2016/17) have increased over time. The number of children in care, as a percentage of the total child population, may indicate the extent to which families are struggling to care and provide safety for their children. It may also be seen as a broad measure of the well-being of children in a community.

**Figure 2.19 Number of children in care, Indigenous and non-Indigenous, Manitoba, 2001/02 to 2016/17**

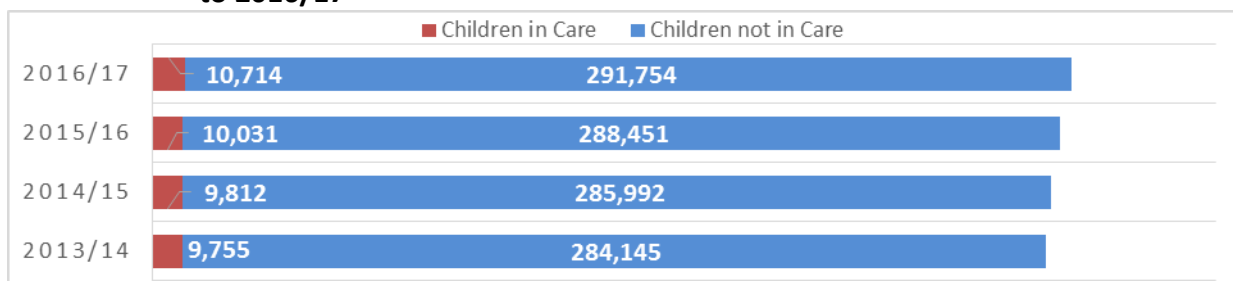


Source: Manitoba Family Services. Annual Reports. 2001/02 to 2016/2017. [https://www.gov.mb.ca/fs/about/annual\\_reports.html](https://www.gov.mb.ca/fs/about/annual_reports.html) (Accessed November 7, 2017)

At March 31, 2017, 10,714 (3.5%) of Manitoba children were in the care of a child and family services agency. Of these children, 56% were permanent wards and 6% were under a voluntary placement agreement with guardians. These voluntary, out-of-home care placements include respite for children with complex needs and is provided for a temporary period. The remaining percentages of these children in care were under a temporary legal status (apprehension or temporary order) where reunification with families is the primary goal. At March 31, 2016, 10,031<sup>c</sup> (3.4%) of Manitoba children were in the care of a child and family services agency (Figure 2.20).

<sup>c</sup> Data on children in care is collected by the Department of Families, annually. Child population data was provided by the Department of Health, Seniors and Active Living (2015/16 to 2016/17), and by Manitoba Bureau of Statistics (2013/14 to 2014/15). Figures have been adjusted in 2016/17 to reflect current reporting practices and offer a meaningful year-over-year comparison. The Department of Families has discontinued the practice of counting children who are placed at home with parents, guardians or permanent families, where no financial contribution was made to their care, as “children in care.”

**Figure 2.20 Children in care as a proportion of the child population in Manitoba, 2013/14 to 2016/17**



Source: Manitoba Family Services. Annual Reports. 2001/02 to 2016/2017. [https://www.gov.mb.ca/fs/about/annual\\_reports.html](https://www.gov.mb.ca/fs/about/annual_reports.html) (Accessed November 7, 2017)

There is an over-representation of Indigenous (First Nations, Métis, and Inuit) children in care in Manitoba. While approximately 26% of the child population in Manitoba are Indigenous, they accounted for 89% of children in care on March 31, 2017. This over-representation reflects historical social and health inequities and injustices experienced by Indigenous communities. The intergenerational impacts of Residential Schools, marginalization and racism is directly related to the higher proportion of Indigenous children in care. Families may struggle with poverty, addictions, family violence or childhood trauma that result in children who are impacted in the care and nurturing they receive. Despite the challenges, there are children in care who experience stability and connection to their family of origin.

The number of children reported to be living with their parent, guardian or a lifelong family member in non-paid care has significantly increased since 2016, from 470 children on March 31, 2016 to 638 children on March 31, 2017. This increase demonstrates a positive movement toward reunification with family.

## 2.7 Socioeconomic Status

Socioeconomic status (often measured by income, education, or occupation, or a combination of two or more of these indicators) is an important factor in child development. Early childhood socioeconomic status can be an important predictor of brain development, learning, behaviour and other health outcomes. Children living in lower socioeconomic circumstances are more likely to have adverse childhood experiences and to encounter harmful levels of stress. Children exposed to early, serious and prolonged stress are at much greater risk for behavioural problems and chronic diseases.

### 2.7.1 Poverty, Low Income, and Income Assistance

Living in poverty affects children from birth through adulthood. There are a number of negative outcomes associated with childhood poverty, particularly with deep, long-term poverty and with poverty in early childhood. Poverty is associated with negative academic outcomes. It negatively affects social and emotional development and can lead to risk of mental health and behavioural problems. Children who live in persistent poverty are more likely to experience poverty as adults. They are more likely to develop chronic health problems, such as diabetes and asthma, and to suffer from unintentional injuries. Children living in persistent poverty are likely to have less positive relations, lower self-esteem and are a higher risk of teen parenting.<sup>19</sup>

Statistics Canada reports on three methods to set low-income thresholds: the Market Basket Measure (MBM), the Low Income Measure (LIM) after tax, and the Low–Income Cut-offs (LICO) after tax. All three thresholds have advantages and disadvantages. The Manitoba Government uses the MBM for reporting poverty in Manitoba because it considers cost of living differences against the cost of basic necessities. These three low-income thresholds are presented to measure poverty.

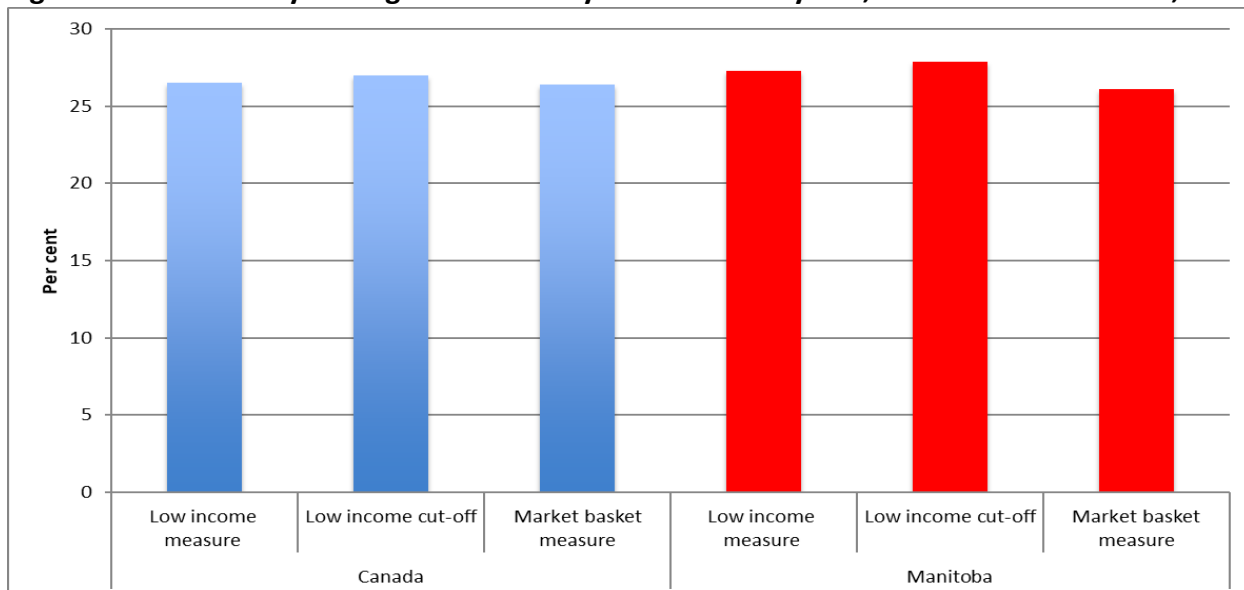
**The Market Basket Measure (MBM)**, designed by a working group of federal, provincial and territorial officials led by Employment and Social Development Canada (formerly Human Resources and Skills Development Canada) between 1997 and 1999, is a measure of low income based on the cost of a specific basket of goods and services representing a modest, basic standard of living. It attempts to measure a standard of living that is a compromise between subsistence and social inclusion and reflects differences in living costs across regions. The MBM represents the cost of a basket that includes: a nutritious diet, clothing and footwear, shelter, transportation, and other necessary goods and services (such as personal care items or household supplies). It provides thresholds for finer geographic levels than the LICO or LIM, allowing for example, different costs for rural areas in different provinces. The MBM is reviewed and updated periodically. These thresholds are compared to the disposable income to determine the low-income status.

**The Low Income Measure (LIM) after tax** is a relative measure of low income, set at 50% of median adjusted household income, where “adjusted” indicates that household needs are taken into account. Adjustment for household sizes reflects the fact that a household’s needs increase as the number of members increases, but also the economies of scale inherent in increasing household size.

**The Low Income Cut-Off (LICO) after tax** is an income threshold below which a family will likely devote a larger share of its after-tax income on the necessities of food, shelter and clothing than the average family. The approach is essentially to estimate an income threshold at which families are expected to spend 20 percentage points more than the average family on food, shelter and clothing, based on the 1992 Family Expenditures Survey. LICOs are calculated in this manner for seven family sizes and five community sizes.

According to the LIM (after tax), 22% of Manitoba children and youth under 18 lived in poverty in 2015. According to the LICO (after tax), 12% of Manitoba children and youth under 18 lived in poverty in 2015. According to the MBM, 16% of Manitoba children and youth under 18 lived in poverty in 2015 (Figure 2.21). For all three measures poverty was higher in Manitoba than in Canada overall (Figure 2.21).

**Figure 2.21 Poverty among children and youth under 18 years, Manitoba and Canada, 2015**



Source: Statistics Canada. Table 206-0041: Low-income statistics by age, sex and economic family type, Canada, provinces and selected census metropolitan areas (CMAs), annual (accessed: September 16, 2017) <http://www5.statcan.gc.ca/cansim/a47>

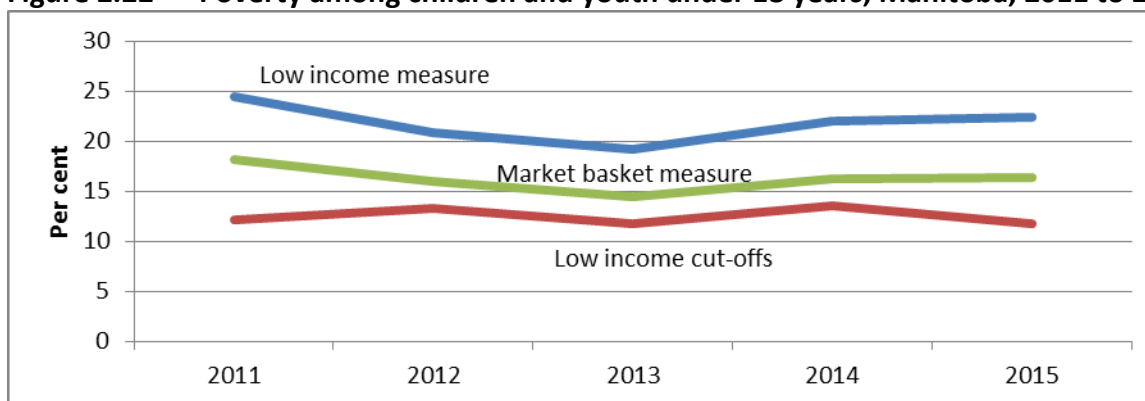
Note: Low income measure and low income cut-offs are both after tax.

Indigenous children and youth are more likely to live in poverty than are non-Indigenous youth. In 2011, 76% of Indigenous children and youth in Manitoba living on reserve lived in poverty. The rate was better, but still high, for Indigenous children living off reserve at 39%.<sup>20</sup>

### 2.7.2 Poverty Reduction

The poverty rate declined from 2011 to 2013 and then rose again, according to all three measures (Figure 2.22).

**Figure 2.22 Poverty among children and youth under 18 years, Manitoba, 2011 to 2015**



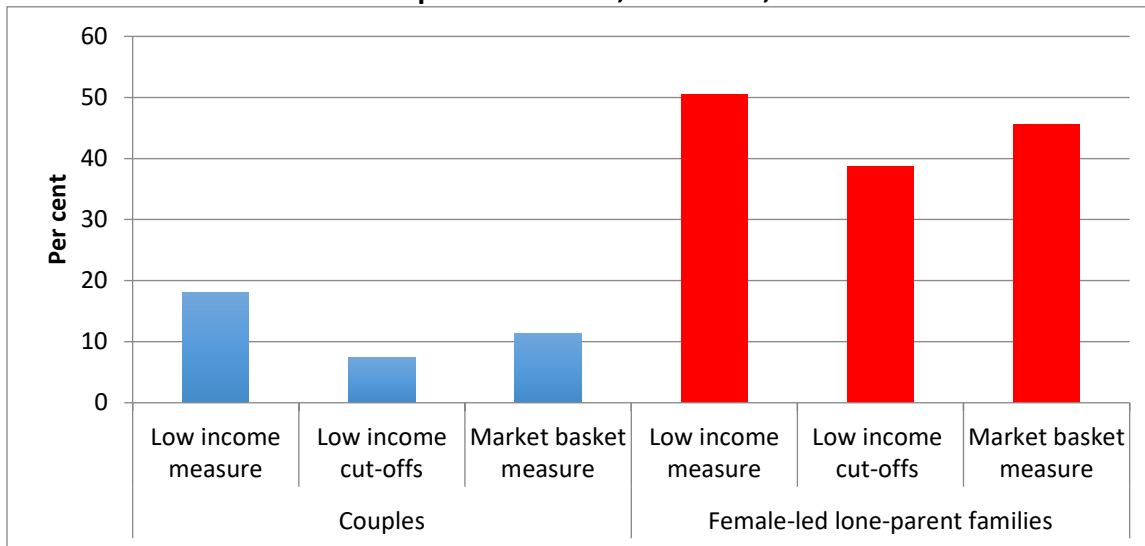
Source: Statistics Canada. Table 206-0041 - Low-income statistics by age, sex and economic family type, Canada, provinces and selected census metropolitan areas (CMAs), annual (accessed: September 16, 2017) <http://www5.statcan.gc.ca/cansim/a47>

Note: Low income measure and low income cut-offs are both after tax.

Children’s risk of poverty varies with the make-up of their families. Children and youth living in female-led lone-parent families are more likely to live in poverty according to all three measures (Figure 2.23). Children and youth living in female-led lone-parent families are 3 times more likely to live in poverty than are those living in couple families according to the LIM. In

2015, children and youth living in female-led lone-parent families were 4 times more likely to live in poverty than those living in couple families according to the MBM (Figure 2.23).

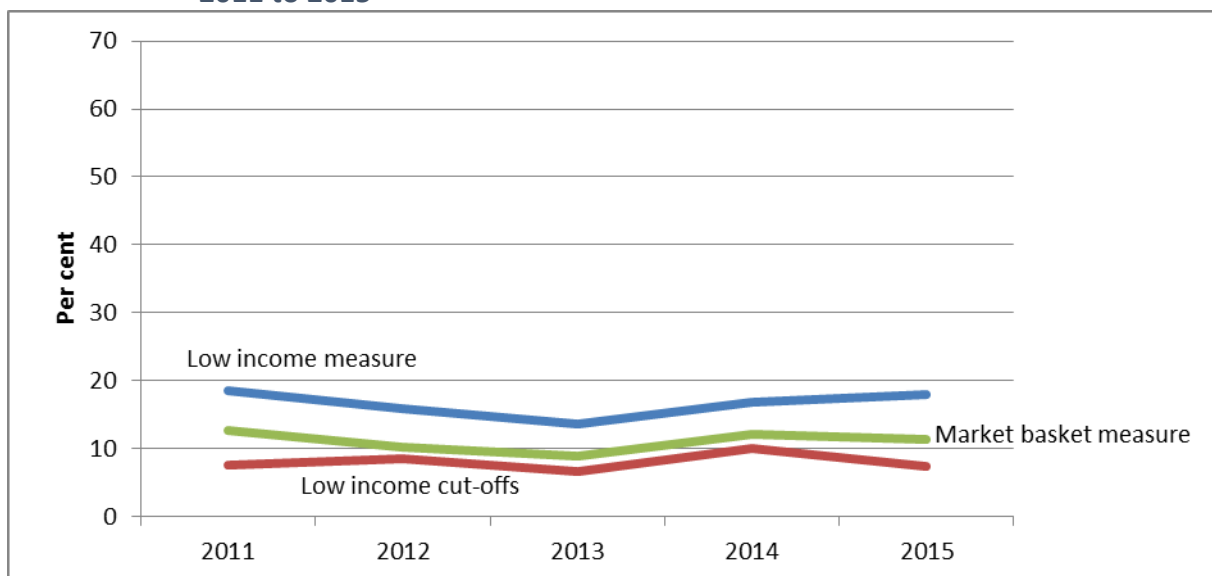
**Figure 2.23 Children and youth under 18 years living in poverty, couple families and female-led lone-parent families, Manitoba, 2015**



Source: Statistics Canada. Table 206-0041 - Low-income statistics by age, sex and economic family type, Canada, provinces and selected census metropolitan areas (CMAs), annual (accessed: September 16, 2017) <http://www5.statcan.gc.ca/cansim/a47>  
 Note: Low income measure and low income cut-offs are both after tax.

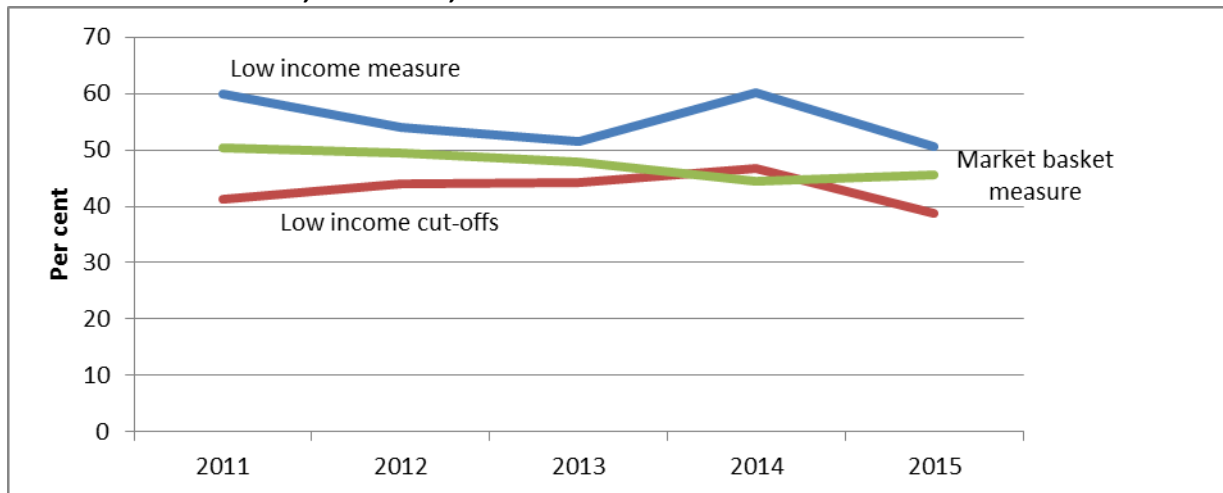
From 2011 to 2015, there has been a modest reduction in poverty on all three measures for female-led lone-parent families, whereas poverty has remained largely unchanged for couple families (Figures 2.24A and 2.24B).

**Figure 2.24A Children and youth under 18 years living in poverty, couple families, Manitoba, 2011 to 2015**



Source: Statistics Canada. Table 206-0041 - Low-income statistics by age, sex and economic family type, Canada, provinces and selected census metropolitan areas (CMAs), annual (accessed: September 16, 2017) <http://www5.statcan.gc.ca/cansim/a47>  
 Note: Low income measure and low income cut-offs are both after tax.

**Figure 2.24B Children and youth under 18 years living in poverty, female-led lone-parent families, Manitoba, 2011 to 2015**



Source: Statistics Canada. Table 206-0041 - Low-income statistics by age, sex and economic family type, Canada, provinces and selected census metropolitan areas (CMAs), annual (accessed: September 16, 2017) <http://www5.statcan.gc.ca/cansim/a47>

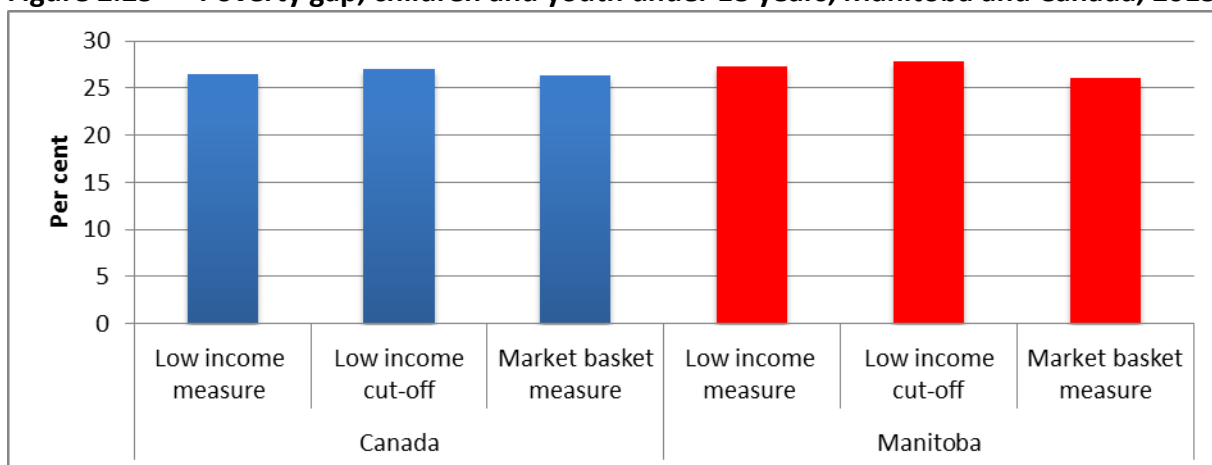
Note: Low income measure and low income cut-offs are both after tax.

Many families are living in extreme poverty. Statistics Canada provides data on the gap ratio, which is used as a measure of the poverty gap to indicate a family's level of poverty (Figure 2.25).

The gap ratio is the difference between the low-income threshold and the family (or household) income, expressed as a percentage of the low-income threshold. For those with negative income, the gap ratio is set to 100. As a measure of depth of low income, the statistic takes the form of the average of the gap ratio calculated over the population of individuals below the income line.

In Manitoba, the poverty gap for children and youth under 18 years old is 27% according to the LIM, 28% according to the LICO and 26% according to the MBM. Therefore there is not much difference between the three measures (Figure 2.25).

**Figure 2.25 Poverty gap, children and youth under 18 years, Manitoba and Canada, 2015**



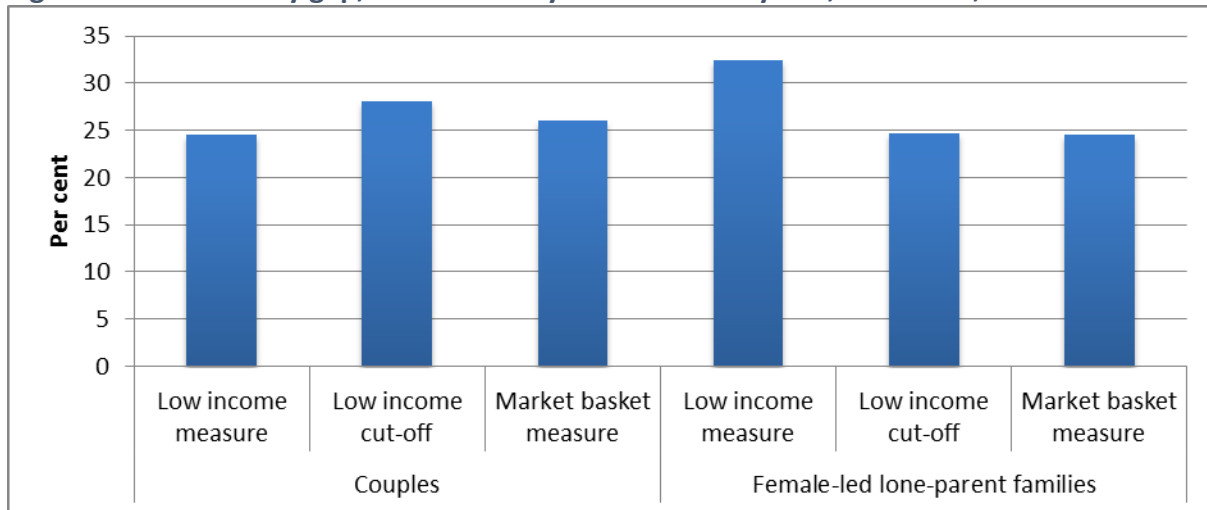
Source: Statistics Canada. Table 206-0041 - Low-income statistics by age, sex and economic family type, Canada, provinces and selected census metropolitan areas (CMAs), annual. (Accessed: September 16, 2017). <http://www5.statcan.gc.ca/cansim/a47>

Note: Low income measure and low income cut-offs are both after tax.

For children and youth under 18 years old living in couple families the poverty gap was 25% according to the LIM, 28% according to the LICO and 26% according to the MBM in 2015. For

children and youth under 18 years living in female-led lone-parent families, the poverty gap was 32% according to the LIM, 25% according to the LICO and 25% according to the MBM in 2015 (Figure 2.26). Therefore, according to the LIM, female-led lone-parent families had a higher poverty gap, but this large difference was not found in the MBM and LICO measures.

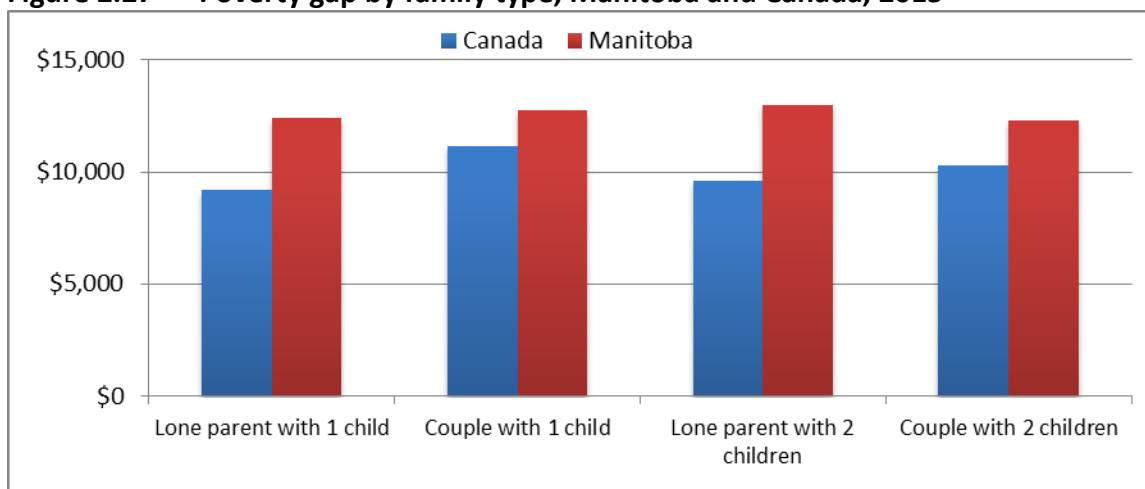
**Figure 2.26 Poverty gap, children and youth under 18 years, Manitoba, 2015**



Source: Statistics Canada. Table 206-0041 - Low-income statistics by age, sex and economic family type, Canada, provinces and selected census metropolitan areas (CMAs), annual. (Accessed: September 16, 2017). <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=2060041>  
 Note: Low income measure and low income cut-offs are both after tax.

Another way of looking at the poverty gap is to look at how much income a family would need to reach the poverty line. In 2015, the average lone parent with one child needed a further \$12,408 income per year to reach the poverty line in Manitoba. That was higher than the figure for Canada which was \$9,178 (Figure 2.27).

**Figure 2.27 Poverty gap by family type, Manitoba and Canada, 2015**

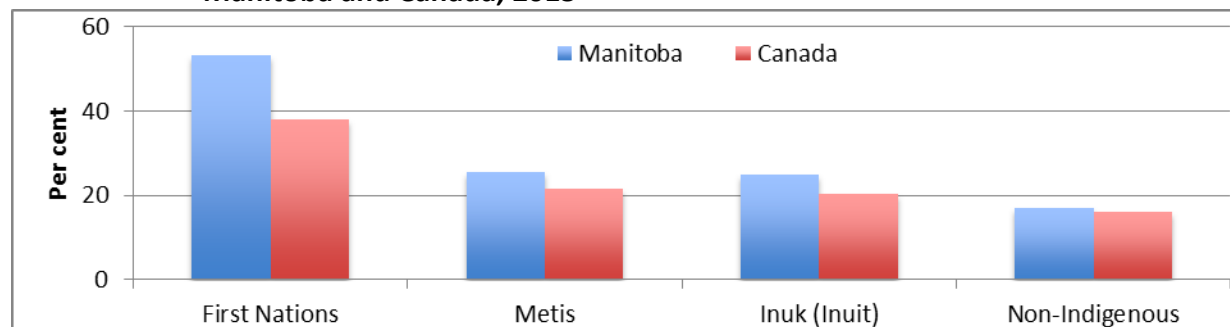


Source: Campaign 2000 and Family Service Toronto. 2017 Report Card on Child and Family Poverty in Canada. A Poverty-Free Canada Requires Federal Leadership. <https://campaign2000.ca/wp-content/uploads/2017/11/EnglishNationalC2000ReportNov212017.pdf>  
 Campaign 2000 and Winnipeg Harvest Inc. Manitoba Child and Family Report Card 2017. Waiting for the Plan. [https://campaign2000.ca/wp-content/uploads/2017/11/2017-MB\\_ChildFamilyPovReportCard\\_FINAL.pdf](https://campaign2000.ca/wp-content/uploads/2017/11/2017-MB_ChildFamilyPovReportCard_FINAL.pdf)

### 2.7.3 Poverty Among Indigenous Children

In 2015, 53% of First Nations children and youth under 18 in Manitoba were living in poverty, as defined by the low income measure after tax, considerably higher than Canada overall at 38%. In Manitoba, the poverty rate was 26% for Métis children, 25% for Inuk (Inuit) children and 17% for non-Indigenous children was (Figure 2.28).

**Figure 2.28 Per cent of children under 18 years living in poverty, by Indigenous identity, Manitoba and Canada, 2015**



Source: Statistics Canada - 2016 Census. Catalogue Number 98-400-X2016173.

<http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GK=0&GRP=1&PID=111095&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=122&VID=0&VNAMEE=&VNAMEF=> Accessed October 27, 2017

Notes: Excludes census data for one or more incompletely enumerated Indian reserves or Indian settlements. Poverty is defined as the Low Income Measure after tax.

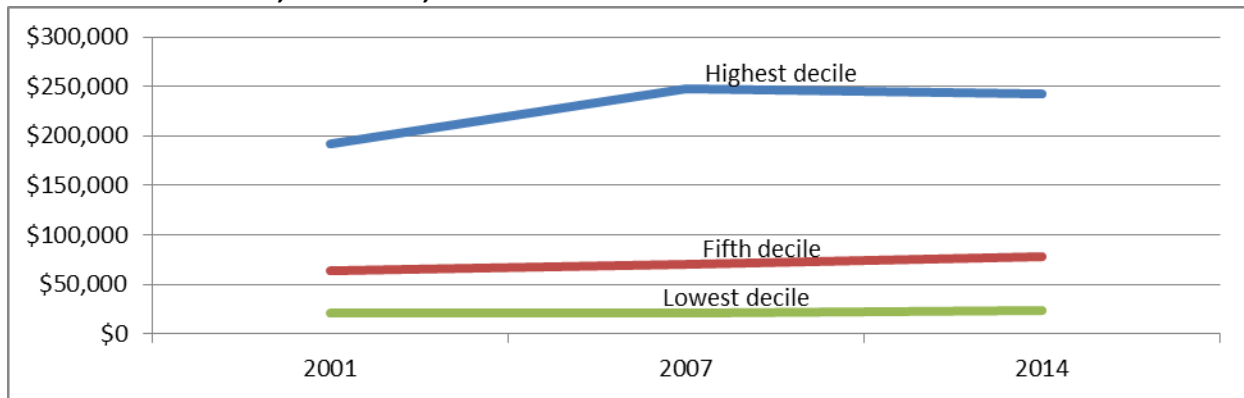
Manitoba's Employment and Income Assistance Program (EIA) provides financial help to Manitobans who have no other way to support themselves or their families. In 2016/17, 5.4% of Manitoba families received assistance from this program.<sup>21</sup> This proportion has been stable since 2001/02.

### 2.7.4 Income Inequality

Income inequality impacts the health of a population, especially among children. Overall, children and families living in societies with greater income inequality will suffer poorer health than those living in societies with less income inequality. Those children and families with the lowest incomes have the worst health outcomes, but the negative impact of inequality is felt among all.<sup>22</sup> The gap between high income and mid-to-low income was relatively stable between 2007 and 2014 but there was a large increase between 2001 and 2007. The mid and low-income families have stayed flat for the past 15 years (2001 to 2014) (Figure 2.29).



**Figure 2.29 After-tax total income (in constant 2014 dollars) for economic families, by decile, Manitoba, 2001 to 2014**



Source: Campaign 2000 & Winnipeg Harvest. Manitoba Child and Family Poverty Report Card 2016.

Note: Average total after-tax income in constant 2014 dollars for each year between 1989 and 2015 for three groups: the 10% of families with the highest income, the 10% of families with the lowest income and 10% of families in the middle (fifth decile).

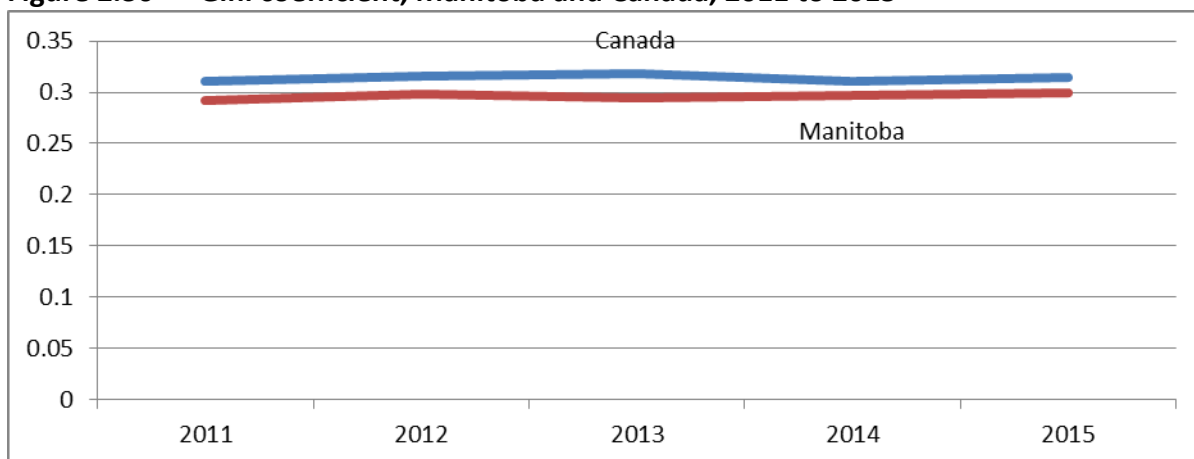
<http://campaign2000.ca/wp-content/uploads/2016/11/MBChildFamilyReportCard2016.pdf> (Accessed August 8, 2017)

The Gini coefficient is another measure of income inequality.

“The Gini coefficient shows the difference between absolute equality (where everyone shares equally in wealth), and actual income distribution. Inequality is expressed as a value ranging from 0 (perfect equality) to 1 (maximum inequality). The Gini coefficient is not necessarily sensitive to changes in income distribution, which can be examined by looking at how after-tax income is distributed across income groups, using income quintiles, or as a percentage share of average after-tax income.”<sup>23</sup>

In 2015, the Gini coefficient in Manitoba was 0.30 based on adjusted after-tax income of economic families (Figure 2.30). According to the Gini coefficient, income distribution equality in Manitoba has been relatively consistent (Figure 2.30).

**Figure 2.30 Gini coefficient, Manitoba and Canada, 2011 to 2015**



Source: Statistics Canada. Table 206-0033 - Gini coefficients of adjusted market, total and after-tax income, Canada and provinces, annual (accessed: October 06, 2017)

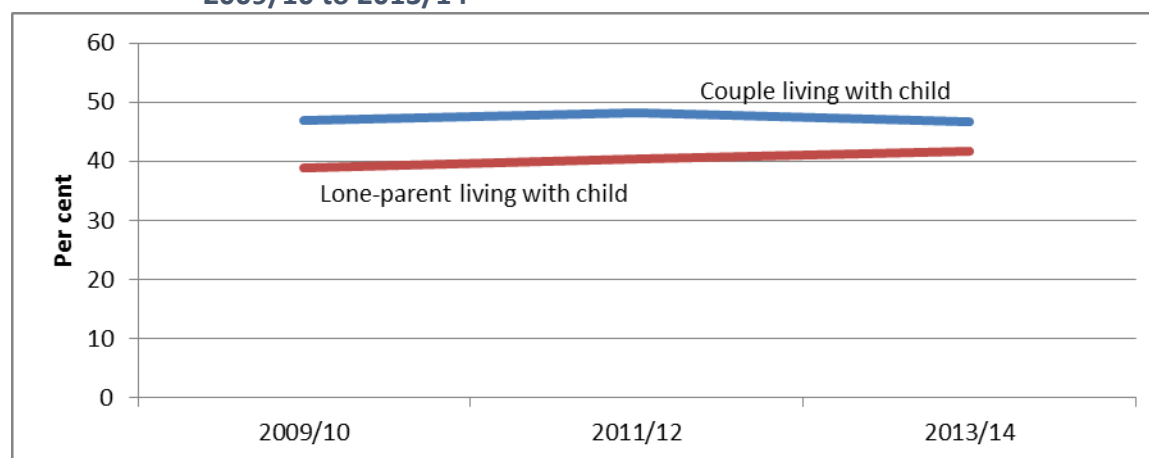
<http://www5.statcan.gc.ca/cansim/pick-choisir?lang=eng&p2=33&id=2060033>

### 2.7.5 Education of Parents

Higher levels of parent educational attainment are strongly associated with positive outcomes for children in many areas, including incidence of low birth weight, school readiness, educational achievement, health-related behaviours including smoking and binge drinking, and prosocial activities. Children with more educated parents are also likely to have access to greater material, human, and social resources.<sup>24</sup>

In 2013/14, 47% of couples living with children in Manitoba had at least one parent who had a post-secondary diploma or degree, compared to 56% in Canada. In Manitoba, 42% of lone parents had a post-secondary diploma or degree compared to 45% in Canada. The proportion of children in two-parent families, who had at least one parent with a post-secondary diploma or degree increased slightly between 2009/10 and 2011/12 and then decreased slightly in 2013/14. The proportion of lone parents with a post-secondary diploma or degree increased slightly (Figure 2.31). In Manitoba, 23% of couple families had one parent with less than secondary school education compared to 20% in Canada, whereas 35% of lone parents in Manitoba had less than a secondary school education compared to 29% in Canada.<sup>25</sup>

**Figure 2.31 Percentage of parents with post-secondary degree/diploma, Manitoba, 2009/10 to 2013/14**



Source: Canadian Community Health Survey 2013-2014 & 2011-2012 & 2009-2010, Public Use Data Set, Accessed through ODESI.  
Notes: This variable indicates the highest level of education acquired by the respondent. Using categories (parent living with spouse and child; parent living with child) from the living arrangement question. Does not capture those parents with children where the parents are not living with child. The Canadian Community Health Survey does not include families living in First Nations communities.

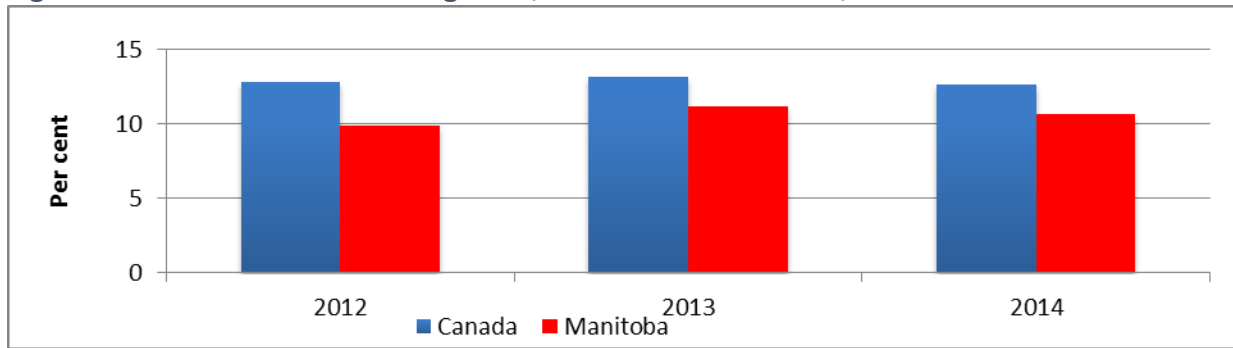
### 2.7.6 Housing

Adequate housing is considered a basic prerequisite for good health, which is particularly true for young children. Studies show that children living in crowded, inadequate or unsafe housing conditions are at an increased risk of chronic and infectious diseases; poor school performance; injuries in the home and malnutrition due to money being needed for housing. In addition, their parents have more stress and worry, and this poses the risk of negatively influencing their parenting.<sup>26</sup>

Core housing need refers to housing that is inadequate, unsuitable, or unaffordable.<sup>27</sup>

Figure 2.32 shows that urban core housing need in Manitoba has been between 10% and 11% between 2012 and 2014. Manitoba continues to have a lower percentage of families in urban core housing need compared to the rest of the country.

**Figure 2.32 Urban core housing need, Manitoba and Canada, 2012 to 2014**



Source: Canada Mortgage and Housing. Canadian Housing Observer. 2014.

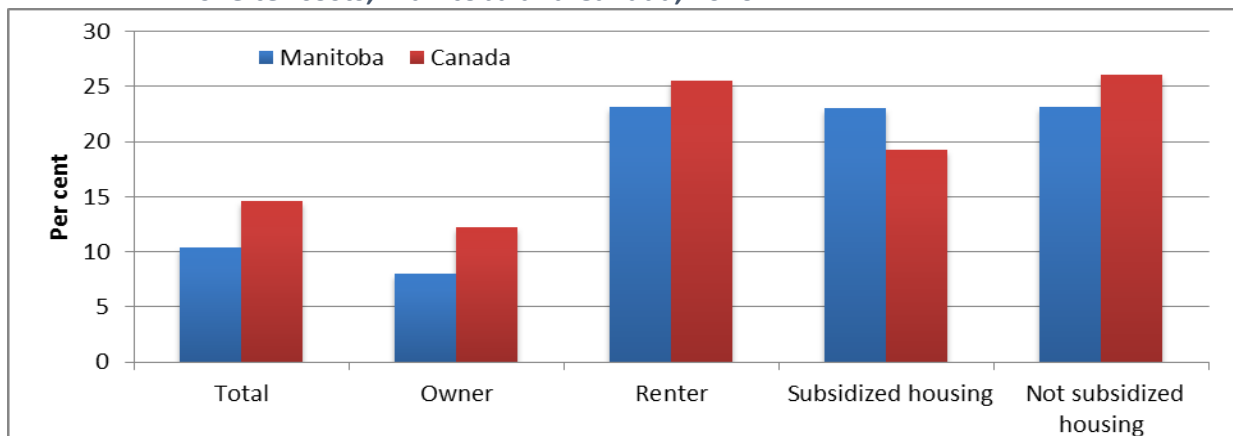
[https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/data\\_013.cfm](https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/data_013.cfm) Accessed August 9, 2017

Note: Acceptable housing is defined as adequate and suitable shelter that can be obtained without spending 30% or more of before-tax household income. Adequate shelter is housing that is not in need of major repair. Suitable shelter is housing that is not crowded, meaning that it has sufficient bedrooms for the size and make-up of the occupying household. The subset of households classified as living in unacceptable housing and unable to access acceptable housing is considered to be in **core housing need**.

Note: These data from the Canadian Income Survey include all individuals in Canada except residents of Yukon, the Northwest Territories and Nunavut, residents of institutions, persons living on reserves and other Aboriginal settlements in the provinces and members of the Canadian Forces living in military camps. Overall, these exclusions amount to less than 3% of the population.

Acceptable housing is defined as adequate and suitable shelter that can be obtained without spending 30% or more of before-tax household income. In 2016, 10% of Manitoba households with children spent more than 30% of their income on shelter costs compared with 15% of households in Canada overall. In Manitoba and Canada, renters were more likely than owners to spend 30% or more of their income on shelter costs. In Manitoba, the proportion was the same for households that were subsidized and not subsidized (Figure 2.33).

**Figure 2.33 Per cent of households with children spending 30% or more of income on shelter costs, Manitoba and Canada, 2016**



Source: Statistics Canada - 2016 Census. Catalogue Number 98-400-X2016229.

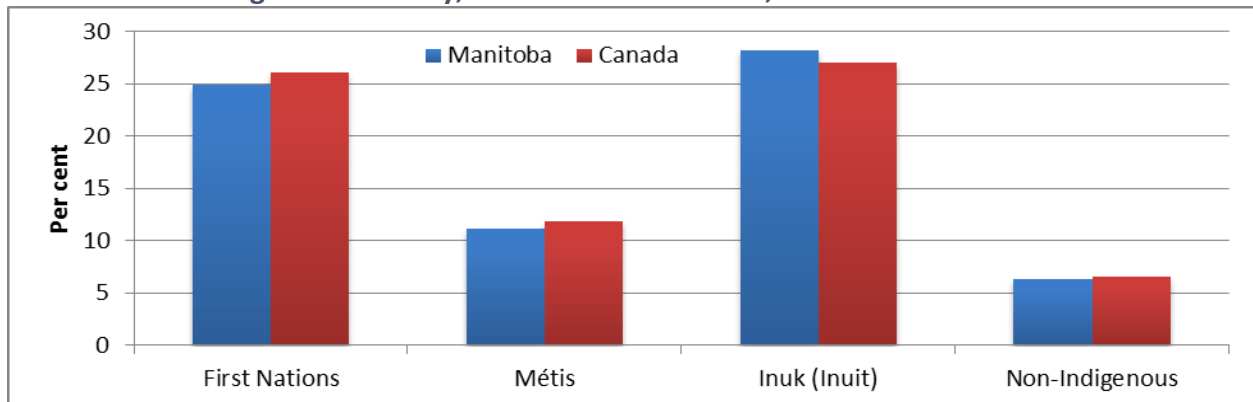
<http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GK=0&GRP=1&PID=110573&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=121&VID=0&VNAMEE=&VNAMEF=> Accessed October 26, 2017

Note: Excludes census data for one or more incompletely enumerated Indian reserves or Indian settlements.

Indigenous families are more likely to live in substandard housing compared to non-Indigenous families. According to the 2011 National Household Survey, 22% of Indigenous Manitobans (off-reserve) lived in core housing compared with 8% of non-Indigenous Manitobans.<sup>28</sup>

In 2016, one-quarter of Manitoba First Nations children under 15 lived in housing that was in major need of repair, compared with 11% of Métis children, 28% of Inuk (Inuit) children and 6% of non-Indigenous children in Manitoba. The rates for Canada overall were similar to those for Manitoba across those four groups (Figure 2.34).

**Figure 2.34 Per cent of children under 15 years living in housing in major need of repair, by Indigenous identity, Manitoba and Canada, 2016**



Source: Statistics Canada - 2016 Census. Catalogue Number 98-400-X2016166.

<http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GK=0&GRP=1&PID=110521&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=122&VID=0&VNAMEE=&VNAMEF=> Accessed October 26, 2017

Notes: Major repairs needed includes dwellings needing major repairs such as dwellings with defective plumbing or electrical wiring and dwellings needing structural repairs to walls, floors or ceilings. Excludes census data for one or more incompletely enumerated Indian reserves or Indian settlements.

Manitoba has a number of programs to support the housing needs of families. Manitoba Housing rents affordable and suitable housing to Manitobans in need. In a personal communication, Lucia Madariaga-Vignudo of Manitoba Housing noted that, as of November 1, 2017, 12,473 persons 18 years and younger are living in Manitoba Housing’s direct managed stock.

### 2.7.7 Homelessness

Although homelessness is difficult to quantify because of hidden homelessness, “point-in-time” counts can assist us to better understand the picture of homelessness in Manitoba. On the night of October 25, 2015, there were at least 1,400 people experiencing homelessness in Winnipeg. Of these people, 27% were youth under the age of 30. The median age at which these people first became homeless was 24 years, and the most frequent age was 18 years. Of all the people who were homeless, 71% self-identified as Indigenous.<sup>29</sup>

A point-in-time (PIT) count is a one-day snapshot of homelessness in shelters and on the streets within a community. A PIT count estimates how many individuals are experiencing homelessness in emergency shelters, transitional housing and unsheltered locations, on the day of the count. A PIT count can also include people who are in health or corrections facilities – such as hospitals, detox centres and jails – and who do not have a place to go when they are released. The City of Winnipeg, Manitoba, conducted a PIT count of homelessness on October 25, 2015.

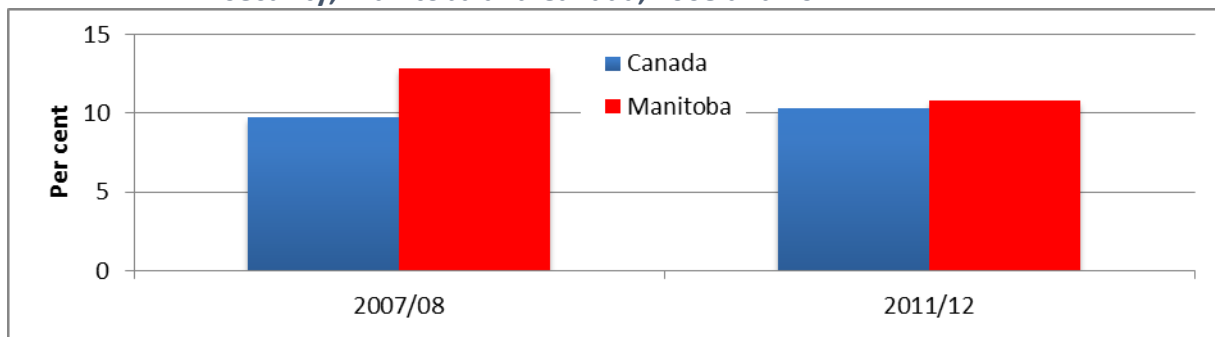
### 2.7.8 Food Insecurity

Food insecurity is the term used to describe hunger in rich countries, and it is an important determinant of child health outcomes, including chronic conditions and mental health

problems. Food insecurity is closely related to poverty and inequality, and is associated with decreased consumption of healthy, nutrient-rich foods.

In 2011/12, 11% of Manitoba households with children under 18 experienced food insecurity, down from 13% in 2007/08. The rate of food insecurity continues to be higher in Manitoba than in Canada overall (Figure 2.35).

**Figure 2.35 Per cent of households with children under 18 years experiencing food insecurity, Manitoba and Canada, 2008 and 2012**



Source: Statistics Canada. Table 105-0546 - Household food insecurity measures, by presence of children in the household, Canada, provinces and territories. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1050546&p2=33> Accessed September 11, 2017.

Notes: Based on the Household Food Security Survey Module, 18-item questionnaire (10 questions for adult food insecurity, 8 questions for child food insecurity), international validated and reliable (Rasch modelling), in English and French)

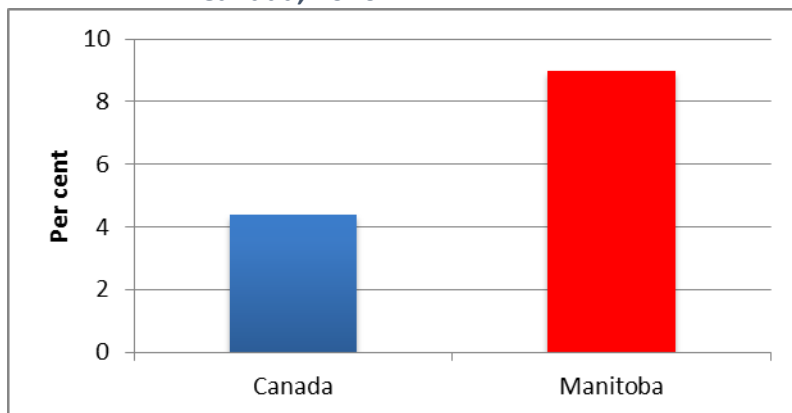
Food insecurity is moderate + severe food insecurity. Moderate food insecurity: compromises in quality and or quantity of food due to a lack of money for food. (2-5 affirmative adult questions, 2-4 affirmative child questions) Severe food insecurity: miss meals, reduce food intake and go days without food. (2-6 or more affirmative adult questions, 5 or more affirmative child questions)

The Canadian Community Health Survey does not include families living in First Nations Communities.

Dependency on food banks is another indicator of food insecurity. Food banks offer emergency assistance to those who need food. Over the past decade, food bank usage has increased across Canada and in Manitoba. In March 2016, food banks provided emergency food assistance to 61,914 people across Manitoba. The number of people using food banks is up 53% from March 2008. The number has declined slightly since 2012. In Manitoba, 43% of those assisted in March 2016 were children, which was higher than the Canadian percentage where 36% of all food bank users were children.<sup>30</sup>

The proportion of children and youth using food banks is higher in Manitoba (9%) than it is in Canada overall (4%) (Figure 2.36).

**Figure 2.36 Per cent of all children ages 0 to 17 who used food banks, Manitoba and Canada, 2016**



Source: Campaign 2000 & Winnipeg Harvest. Manitoba Child and Family Poverty Report Card 2016. Available from: <http://campaign2000.ca/wp-content/uploads/2016/11/MBChildFamilyReportCard2016.pdf> (Accessed August 10, 2017)

## 2.8 Summary

- Children and youth (ages 0-19 years) represent a quarter of Manitoba's population (25.3%, over 335,000), proportionally more than Canada (22%). Over the past decade, the number of children ages 0-4 years has increased by 21%.
- Over half of children and youth in Manitoba (56%) live in urban settings.
- Since 2000, most Manitoba children and youth (76%) live in two-parent families. Proportionally more live in single parent families (24%), compared to Canada (21%).
- Our province's young people are diverse in culture, ethnicity, identity, and language.
  - More than one in four (29%) (90,000 children ages 0-19) are Indigenous (First Nation, Métis and Inuit), almost 4 times higher than Canada, and growing over time. Thirty per cent of Manitoba's children ages 0-5 are Indigenous compared to only 8% in Canada overall.
  - Since 2012, the number of newcomer children and youth, born in other countries, who made Manitoba their permanent home has grown by 33%. A larger proportion of Manitoba's newcomers are younger, compared to Canada.
  - The most commonly spoken non-official languages in Manitoba are Tagalog (Filipino), German, Punjabi, Cree, Ojibway, Spanish, and Mandarin.
  - One in five Manitoba young people are from a visible minority group.
- Since 2001, the number of children in care has grown, from 1.9% to 3.5% of all children; this group is predominantly Indigenous.
- Socioeconomic status is an important factor in child development. Early childhood socioeconomic status can be an important predictor of brain development, learning, behaviour and other health outcomes. Children living in lower socioeconomic circumstances are more likely to have adverse childhood experiences and to encounter harmful levels of stress.
- Children in specific demographic segments are more likely to experience poverty than the general population. Acute rates of child poverty exist among lone-parent families and Indigenous families, notably among First Nation families living on reserve where child poverty rate is extremely high. Poverty presents challenges in accessing nutritious food as well as adequate, suitable and affordable housing, contributing to the risk of negatively influencing the health outcomes of children.

- Adequate housing is considered a basic prerequisite for good health. This is particularly true for young children.
- Food insecurity is the term used to describe hunger in rich countries, and it is an important determinant of child health outcomes, including chronic conditions and mental health problems.
- Higher levels of parent educational attainment are strongly associated with positive outcomes for children in many areas of development including school readiness, educational achievement, health and prosocial activities.
- Child poverty in Manitoba ranges from 12% to 22%, depending on the measure, and is higher than Canada.
  - Children living in female-led lone-parent families are up to 4 times more likely to live in poverty, children living in compared to couple families.
  - One in two First Nations children, one in four Métis, one in four Inuit, and one in six non-Indigenous children in Manitoba live in poverty, all higher than in Canada overall.
- Fewer Manitoba parents have completed secondary or post-secondary education (47%), compared to Canada (56%).
- Fewer Manitoba families live in urban core housing (10-11%), compared to Canada (13%). Indigenous children are more likely to live in housing in major need of repair.
- Food insecurity is higher for children in Manitoba (11% in 2012), compared to Canada (10% in 2012).

## Chapter 3. Prenatal

The health and well-being of expectant parents influences the health, well-being and development of their unborn children. There are many influences on their health: social and demographic factors, social and physical environments, relationships and supports, and environmental exposures. These influences can be significant and long term.

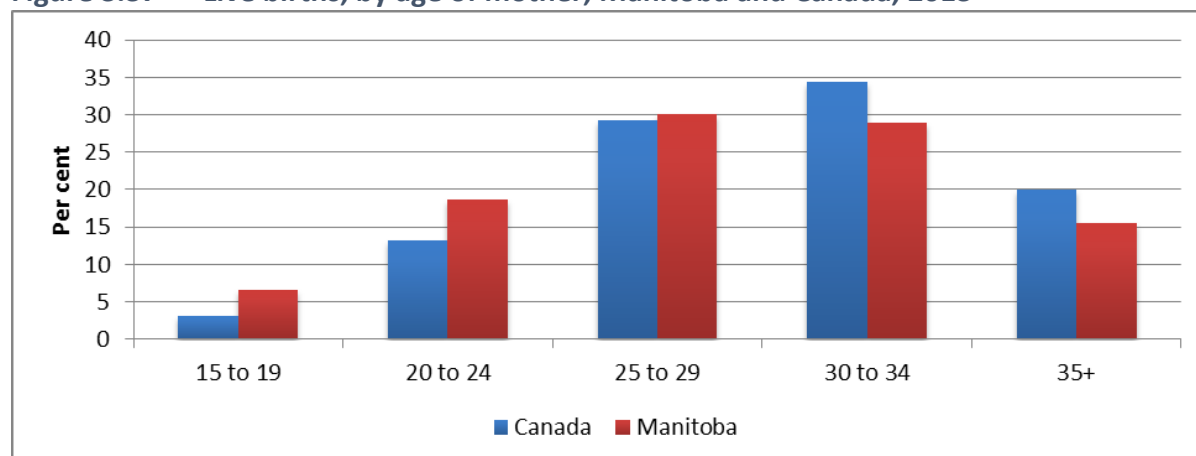
### 3.1 Demographic and Socioeconomic Factors in Pregnancy

Many factors influence the health of parents and therefore the health of their baby. These include a number of demographic and economic factors such as age, education, and income, as well as access to health care.

#### 3.1.1 Age of Mother

The age of the mother at time of birth is an important predictor of several outcomes. In 2013, over three-quarters (78%) of women who gave birth in Manitoba were between the ages of 20 and 34, similar to the percentage in Canada overall (77%). In Canada, there was a higher percentage of older mothers (30 and older), while in Manitoba there was a higher percentage of younger mothers (24 and younger) (Figure 3.37). This difference has not changed since 2003.

**Figure 3.37 Live births, by age of mother, Manitoba and Canada, 2013**



Source: Statistics Canada. Table 102-4503 Live births, by age of mother, Canada, provinces and territories. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1024503> Accessed August 20, 2017

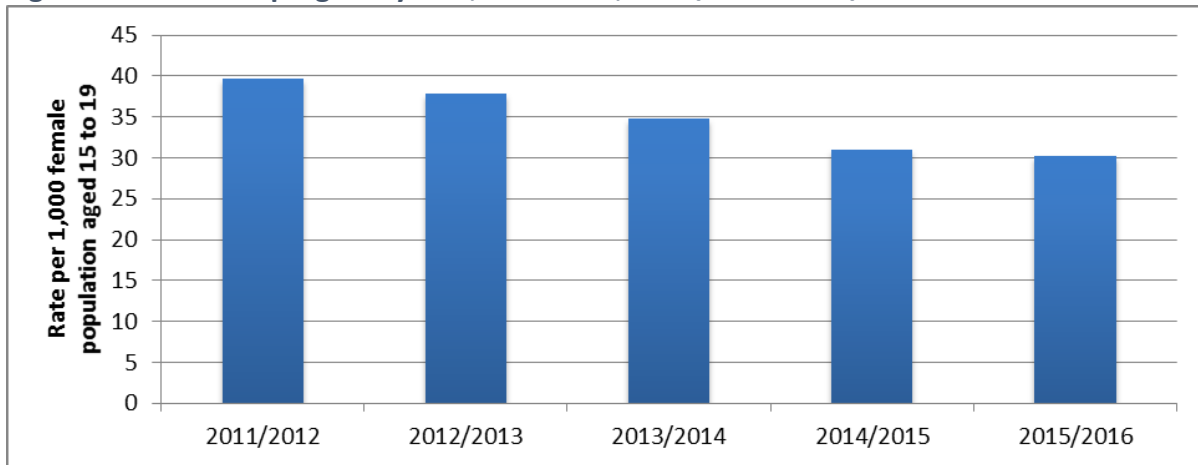
##### 3.1.1.1 Teen pregnancy and birth

Teenage pregnancy can pose risks for both the mother and the baby, particularly if they do not receive support and care when they are pregnant. Pregnant teenagers have a higher risk of developing complications during pregnancy such as high blood pressure and anemia.<sup>31</sup> Babies born to teenage mothers are more likely to be born preterm and low birth weight.<sup>32,33</sup> Teenage mothers are also more likely to suffer from postpartum depression.<sup>34</sup>

The teen pregnancy rate in Manitoba declined between 2011/12 and 2015/16. In 2011/12 the rate was 40 pregnancies per 1,000 teenage females aged 15 to 19; the rate declined to 30 by 2015/16 (Figure 3.38). This decline has been steady since the beginning of the millennium; in 1999/2000, the rate was 62.



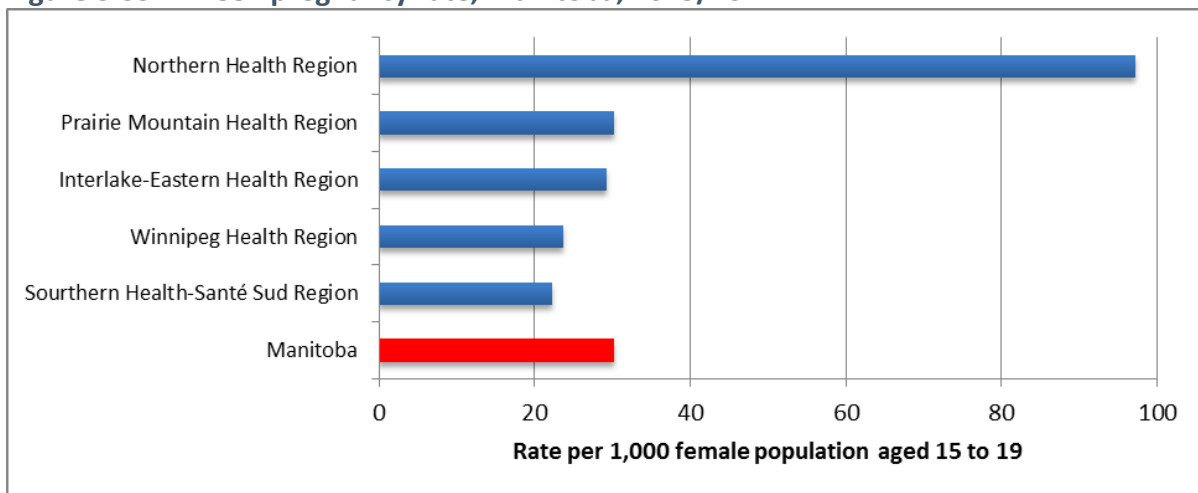
**Figure 3.38 Teen pregnancy rate, Manitoba, 2011/12 to 2015/16**



Source: Discharge Abstract Database. Information Management and Analytics,

There are regional differences in the teen pregnancy rate. In 2015/16, the provincial rate was 30/1,000, but the rates ranged from a low of 22/1,000 in the Southern Health Region to a high of 97/1,000 in the Northern Health Region (Figure 3.39). The rates have been falling in all regions.

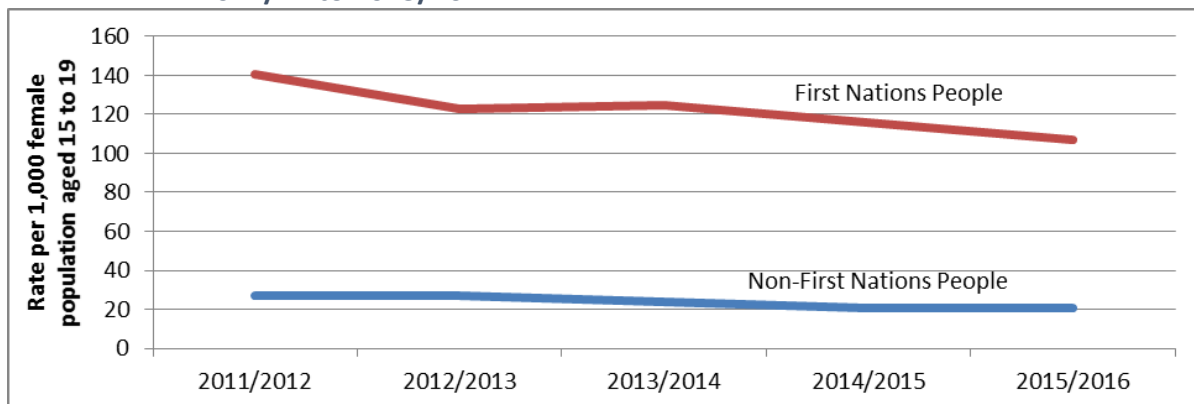
**Figure 3.39 Teen pregnancy rate, Manitoba, 2015/16**



Source: Discharge Abstract Database. Information Management and Analytics, Manitoba Health, Seniors & Active Living

The teen pregnancy rate is higher among First Nations teens than it is among non-First Nations teens, although the rate is declining in both groups. Between 2011/12 and 2015/16 the rate declined by 24% among First Nations teens and 23% among non-First Nations teens (Figure 3.40).

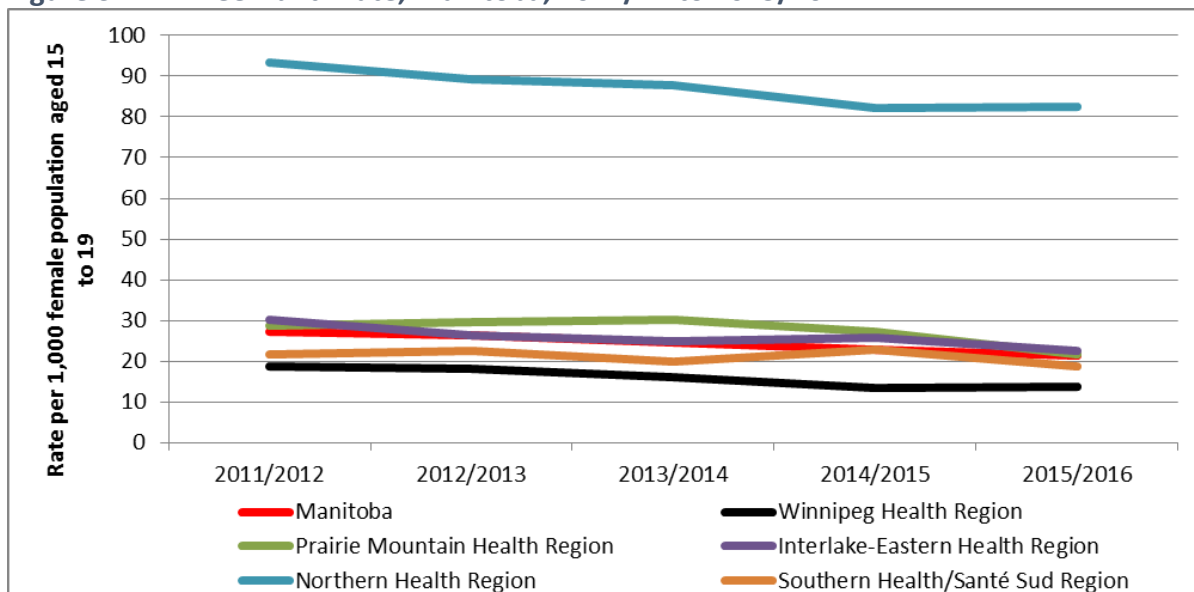
**Figure 3.40 Teen pregnancy rate, First Nations and non-First Nations people, Manitoba, 2011/12 to 2015/16**



Source: Discharge Abstract Database. Information Management and Analytics, Manitoba Health, Seniors & Active Living

According to data collected during interviews between public health nurses and new mothers who gave birth, there were 803 births to teenagers under age 18 in 2015.<sup>35</sup> In 2015/16, the teen birth rate in Manitoba was 21 per 1,000 young women aged 15 to 19. The teen birth rate varied among regions from a high of 82 in the Northern Health Region to a low of 14 in the Winnipeg Health Region (Figure 3.41). For all of Manitoba, the teen birth rate declined by 22% between 2011/12 and 2015/16. The rate declined in all regions, but the decline varied among the regions, from a decline of 27% in the Winnipeg Region to a decline of 12% in the Northern Health Region (Figure 3.41).

**Figure 3.41 Teen birth rate, Manitoba, 2011/12 to 2015/16**



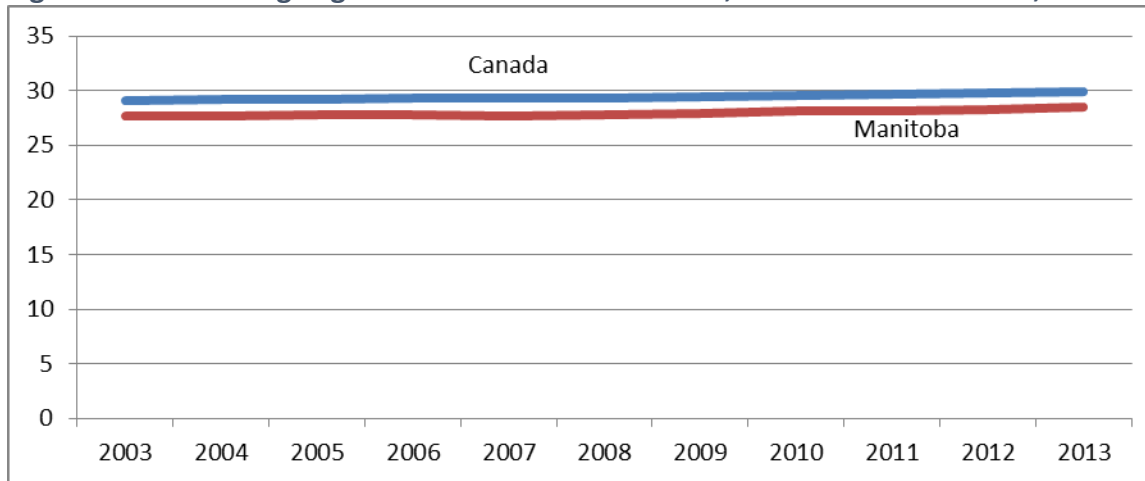
Source: Discharge Abstract Database. Information Management and Analytics, Manitoba Health, Seniors & Active Living

Teenage mothers are at risk of becoming socially isolated and having mental health problems.<sup>36</sup> In addition, pregnancy can interrupt their education and result in fewer employment opportunities.<sup>36</sup> Child and Family Services provides supports to teenagers to mitigate these risks. In 2016/17, Child and Family Services provided supports to 209 minor expectant parents.<sup>21</sup>

### 3.1.1.2 Older mothers

The average age of mothers giving birth in Manitoba has been increasing. Between 2003 and 2013 the average age has increased from 27.7 to 28.5, an increase of 3%. That is similar to the increase in Canada overall; however, the average age of mothers giving birth is slightly lower in Manitoba than it is in Canada (Figure 3.42). In addition, the proportion of live births to mothers 35 years of age and older increased from 9% in 1993 to 13% in 2003 and 16% in 2013.<sup>37</sup> Although there may be advantages to having children later in life, there is a higher risk of complications such as hypertension, caesarean birth, preterm birth and low birth weight associated with pregnancies and births among mothers over the age of 35.

**Figure 3.42** Average age of mothers at time of birth, Manitoba and Canada, 2003 to 2013



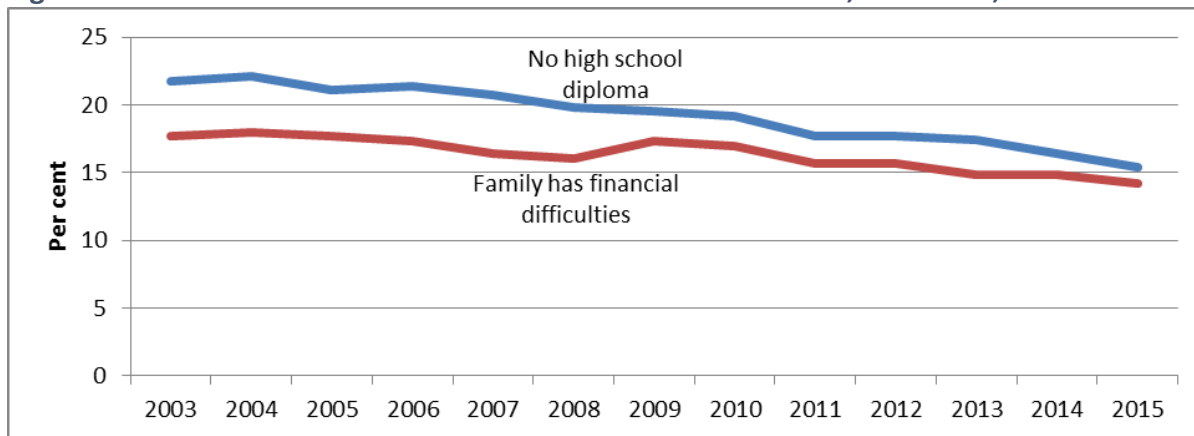
Source: Statistics Canada. Table 102-4504 - Mean age of mother at time of delivery (live births), Canada, provinces and territories, annual (years) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1024504> (Accessed July 24, 2017)

### 3.1.2 Socioeconomic Status

Socioeconomic status is an important factor in healthy pregnancies and healthy babies, with higher levels of income and education associated with better outcomes. The proportion of women with newborns who did not complete high school and had financial difficulties have both declined between 2013 and 2015.

The proportion of women with newborns who did not complete high school decreased from 22% in 2003 to 15% in 2015 (Figure 3.43). In Manitoba, the percentage of new mothers with less than a high school education is higher than the national average.<sup>25</sup> The percentage of new mothers reporting financial difficulties declined between 2003 and 2015, from 18% to 14% (Figure 3.43).

**Figure 3.43 Socioeconomic status of mothers with newborns, Manitoba, 2003 to 2015**

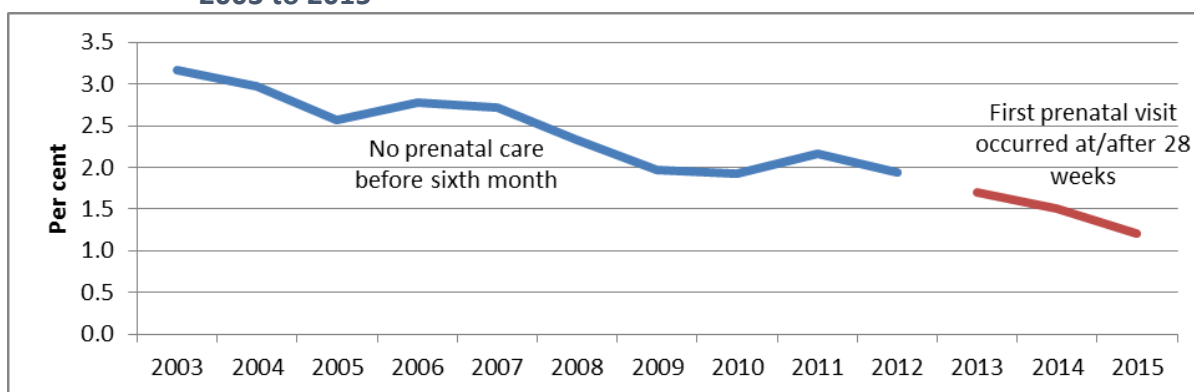


Source: Families First Screen, Healthy Child Manitoba Office  
 Note: Excludes new mothers living in First Nations Communities.

### 3.1.3 Prenatal Care

Early prenatal care is associated with better outcomes.<sup>38</sup> However, appropriate prenatal care depends on the circumstances of each pregnancy and family. The percentage of pregnant women who did not have prenatal care before 28 weeks gestation is very low in Manitoba, 1.2%. The percentage of pregnant women receiving care late in their pregnancy has declined steadily from over 3% in 2003 to 1.2% in 2015 (Figure 3.44). Reports have indicated, however, that there are significant social inequalities in the use of prenatal care. Women living in these types of dis-advantaged neighbourhoods have between two and three times higher rates of inadequate prenatal care than those who live in more advantaged areas. High concentrations of inadequate prenatal care utilization were clustered in the inner-city areas of Winnipeg and in northern Manitoba.<sup>39</sup> Prenatal care utilization was measured using two indices of the number of visits at different periods during gestation.

**Figure 3.44 No prenatal care before sixth month or at/after 28 weeks, Manitoba, 2003 to 2015**



Source: Families First Screen (FFS), Healthy Child Manitoba Office  
 Notes: FFS collects data on whether the mother had prenatal care before 6 months (2003-2012) or at or before 28 weeks gestation (2013 onwards). Excludes new mothers living in First Nations communities.

The Healthy Baby Program in Manitoba includes two components: a prenatal benefit and community support programs (see text box below).

### The Healthy Baby Program

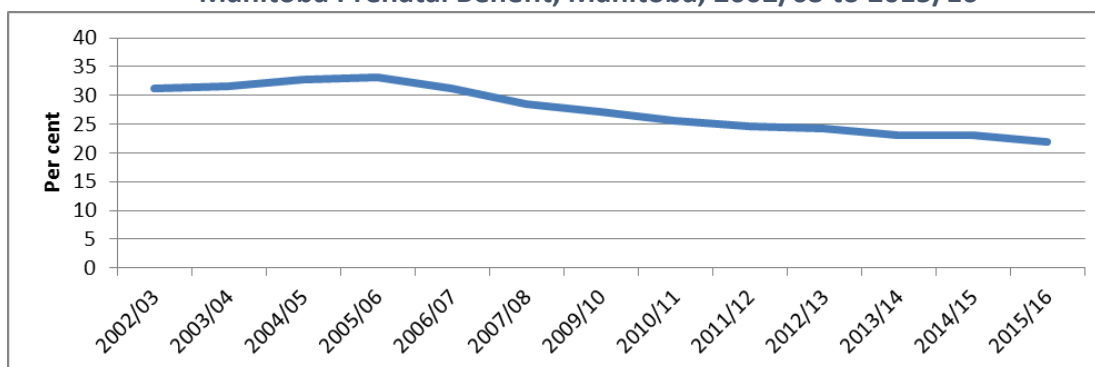
The Healthy Baby Program was introduced in 2001 by the Healthy Child Manitoba Office, with the goal to promote prenatal and perinatal health.

One component of the program is the **Manitoba Prenatal Benefit (MPB)**, which consists of a monthly cheque provided during pregnancy, beginning in the second trimester. The prenatal benefit is available to pregnant parents whose annual net family income is less than \$32,000. The maximum monthly amount is \$81.41, with almost 90% of recipients getting this amount. Along with the monthly cheque, information is provided regarding the benefits of good prenatal nutrition; the consequences of smoking, drinking, or taking drugs during pregnancy; the importance of regular prenatal care; the benefits of exercise and stress reduction; and the importance of early child development, including the benefits of breastfeeding.

The second component of the program is **Healthy Baby Community Support Programs**, which are educational and supportive groups available to all pregnant parents, regardless of income, from the prenatal period through to the infant's first birthday. These programs are free of charge, and encourage early, regular prenatal care, as well as promote healthy infant development. Healthy Baby programs offer group sessions on a weekly, bi-weekly, or monthly basis. The programs generally include information on prenatal nutrition and health, as well as information on parenting. The programs also offer social support, milk coupons (during pregnancy and up to six months after birth), bus tickets to attend programs, and on-site child care.

A Manitoba research report found that women who were young, receiving income assistance, a lone parent, socially isolated, had less than Grade 12 education, or resided in lower-income areas were more likely to receive the MPB and were more likely to participate in community support programs.<sup>40</sup> The number of women receiving the MPB appears to have declined since 2007/08. In 2015/16, 22% of all mothers who had live births in hospital received the MPB (Figure 3.45). Of the women who received the benefit in 2015/16, 32% lived in First Nations communities.<sup>41</sup>

**Figure 3.45 Percentage of all mothers who had live births in hospital and received the Manitoba Prenatal Benefit, Manitoba, 2002/03 to 2015/16**



Sources: Number of mothers receiving the Benefit: Healthy Child Annual Reports 2001-2016.  
 Number of live births in hospital: Information Management & Analytics, Manitoba Health, Seniors and Active Living  
<https://www.gov.mb.ca/healthychild/about/annual.html>

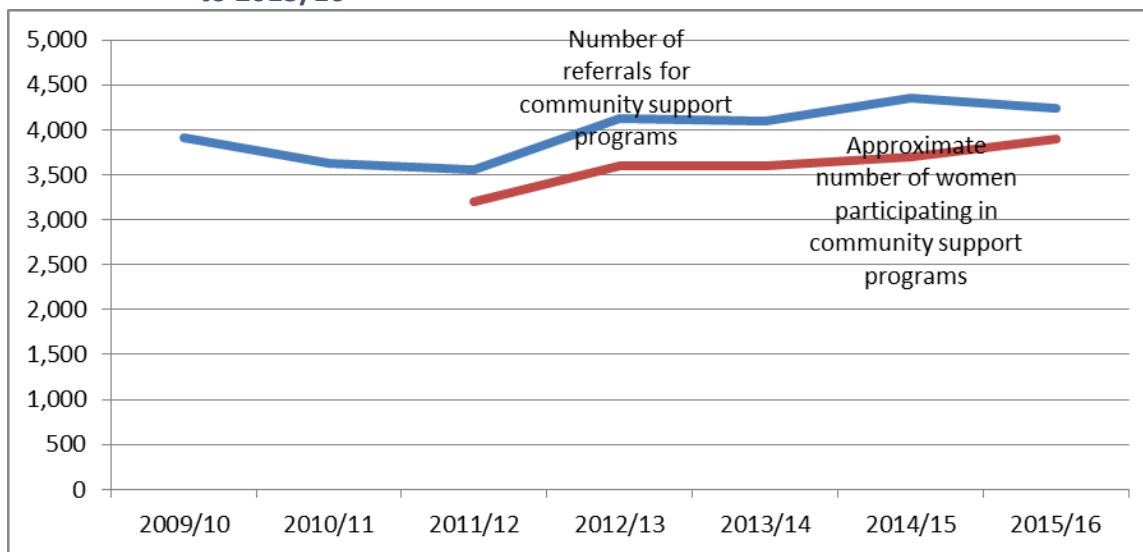
There may be a variety of reasons for the decrease in the number of women receiving the MPB between 2001 and 2015. The income criteria for eligibility has not changed since 2001, while

the median annual salary has risen. This means that fewer families would have been eligible for the benefit. Although there has been an increase in salaries, this increase has not kept pace with inflation and this means that families' earnings are worth less over time. The rates of poverty and income disparity suggest that the need for the MPB in low-income families may not have decreased but the increase in salary has decreased eligibility for the Benefit. Although all women on IA are automatically eligible for the MPB, 28% of women on IA did not receive the benefit.<sup>41</sup> This suggests that there are barriers that prevent eligible women from accessing the MPB. Healthy Child Manitoba Office and Employment and income Assistance are collaborating to identify ways to increase the number of eligible women who access the MPB, given the positive benefits to families and children with low income.

A recent study found that low-income mothers who received the MPB between 2003 and 2010 had better birth outcomes than low-income mothers who did not receive the benefit. Receiving the MPB was associated with reductions in low birth weight, preterm births, and small-for-gestational-age births and increases in breastfeeding and large-for-gestational age births.<sup>42</sup>

The Healthy Baby Community Support Programs are available to all pregnant families free of charge. In 2015/16, there were 4,234 referrals to Healthy Baby Community Support Programs, and 3,900 parents participated.<sup>41</sup> Both the number of referrals and the number of parents participating in community support programs have increased between 2009/10 and 2015/16 (Figure 3.46).

**Figure 3.46 Referral and participation in community support programs, Manitoba, 2009/10 to 2015/16**



Source: Healthy Child Manitoba Annual Reports 2009/10-2015/16. <https://www.gov.mb.ca/healthychild/about/annual.html>

### 3.2 Physical Health During Pregnancy

The health of parents and the environments in which they live influence the health of their infant during pregnancy and beyond.

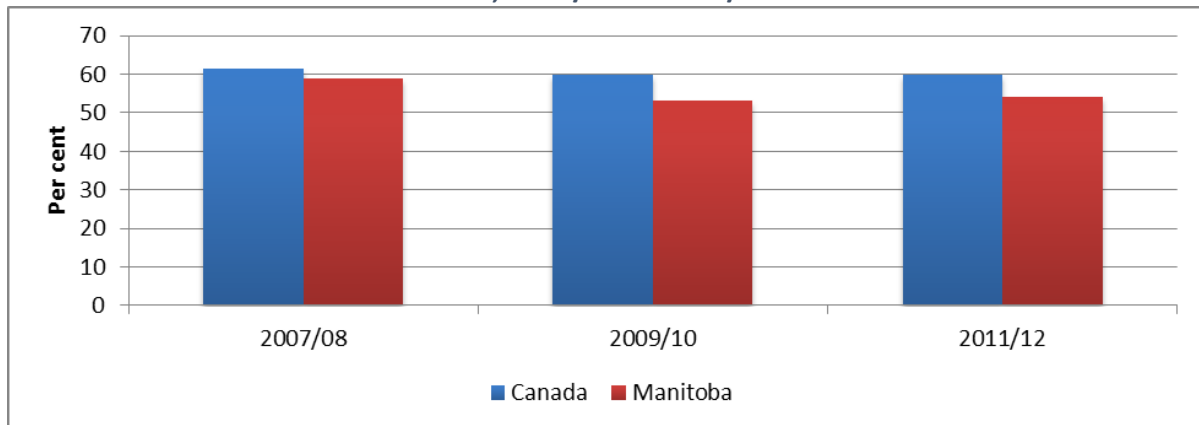
### 3.2.1 Nutrition During Pregnancy

A mother's nutrition during pregnancy influences the mother's health and facilitates the healthy development of the fetus. There is research to indicate that a mother's diet during pregnancy may program the future energy and nutrient metabolism and risk of chronic disease of the child through childhood and into adulthood.<sup>43</sup> There are, however, limited data available related to Canadian expectant parents' nutrition.

Canada's Food Guide recommends that pregnant women eat at least 7 to 8 servings of fruit and vegetables daily.<sup>44</sup> A 2015 survey found that 42% of Manitoba women of childbearing age (18 to 34) ate fruits and vegetables 5 or more times a day compared to 37% of women in Canada overall.<sup>45</sup>

Women with low levels of folic acid have increased risk of having a baby with a neural tube defects such as spina bifida, and it is recommended that women start taking folic acid supplements before they become pregnant.<sup>43</sup> Between 2007 and 2012, the percentage of Manitoba women who took folic acid supplements before their last pregnancy declined from 59% to 54% in 2011/12. The Manitoba rate is lower than the rate for Canada overall, which was 60% in 2011/12 (Figure 3.47).

**Figure 3.47** Percentage of women who took folic acid before their last pregnancy, Manitoba and Canada, 2007/08 to 2011/12



Source: Canadian Community Health Survey 2011-2012 & 2009-2010 & 2007-2008, Public Use Data Set, Accessed through ODESI.  
Note: The Canadian Community Health Survey does not include families living in First Nations Communities.

### 3.2.2 Alcohol and Drug Use During Pregnancy

Alcohol, tobacco and other drug use during pregnancy can have adverse outcomes for the infant, developing child, and beyond into adulthood.

#### Fetal Alcohol Spectrum Disorder (FASD)

FASD is a range of neurological, behavioural, and/or physical issues that result from prenatal alcohol exposure. Prenatal alcohol exposure affects the central nervous and neurological systems. Effects include impairments to attention, language, cognitive processes, adaptive behaviour, memory, executive functioning, motor skills, neuroanatomy, and affect regulation. These effects, in turn, can impact academic achievement, health outcomes, and general well-being. Physical effects may include heart disease, digestive disorders, chronic pain, and facial differences. FASD is referred to as a spectrum disorder because these neurological and physical outcomes can occur in a wide variety of configurations and degrees of severity. FASD is also referred to as an “invisible disability” the majority of people with FASD do not have the commonly associated facial features. Whether or not alcohol exposure leads to FASD depends on a set of biological and social factors that interact in different ways for each person. Biological factors can include a woman’s sensitivity to alcohol, metabolism, and size. Social factors like chronic stress, violence, trauma, or poverty can increase the chances that a baby might be born with FASD.

Determining the prevalence of FASD is difficult due to two major barriers. First, families who have a child that was prenatally exposed to alcohol do not always seek a diagnosis. There may be a variety of reasons for this, such as a lack of knowledge, fear of shame and blame, or a lack of readiness. Second, the diagnostic process is complex, requiring assessments by trained physicians, psychologists and other professionals. Manitoba’s diagnostic capacity continues to improve, including diagnostic clinics in various communities throughout the province. However, waitlists in the larger centres can be 1-2 years, and there are still some remote communities where access to diagnosis and programming remains difficult.

The FASD incidence rate in Canada is estimated to be 9.1 per 1,000 live births.\* Newer research suggests that incidence is even higher, more like 14.2-43.8 per 1000 births.† The prevalence of FASD in children in care in Manitoba is conservatively estimated to be 11%, with an additional 6% being assessed for the disorder.‡

A person with FASD will cost the system an estimated \$800,000 more than the average Canadian over their lifetime.§ The \$800,000 cost will be distributed between sectors including: healthcare (30%), education (24%), social services (19%) justice (14%) and other (13%).

It is important to recognize some recurring patterns in order to fully understand why FASD exists, what we can do to prevent it, and how to support those who it impacts. For women and pregnant mothers, patterns such as trauma caused by abuse, poverty, and systemic racism are all contributing factors to why a woman may drink alcohol during pregnancy. For children and youth with FASD, patterns such as repeated misinterpretations of behaviours at school, repeated mislabeling of behaviours as wilful disobedience, and multiple placements can cause personal trauma, and attachment disorders that keep them from maximizing their potentials.

\* Public Health Agency of Canada (PHAC). (2003). Fetal alcohol spectrum disorder (FASD): A framework for action. Ottawa, ON: PHAC. [http://www.phac-aspc.gc.ca/publicat/fasd-fw-etcaf-ca/pdf/fasd-fw\\_e.pdf](http://www.phac-aspc.gc.ca/publicat/fasd-fw-etcaf-ca/pdf/fasd-fw_e.pdf) (Accessed July 12, 2017).

† <https://www.ncbi.nlm.nih.gov/pubmed/25381628> (Accessed January 18, 2018).

‡ Fuchs, D., Burnside, L., Marchenski, S., & Mudry, A. (2007). Children with FASD involved with the Manitoba child welfare system. [http://cwrp.ca/sites/default/files/publications/en/FASD\\_Final\\_Report.pdf](http://cwrp.ca/sites/default/files/publications/en/FASD_Final_Report.pdf) (Accessed July 12, 2017).

§ Jonsson, E., Dennett, L. & Littlejohn, G. (Eds). Institute of Health Economics, Fetal Alcohol Spectrum Disorder (FASD): Across the Lifespan. Proceedings from an IHE Consensus Development Conference 2009.

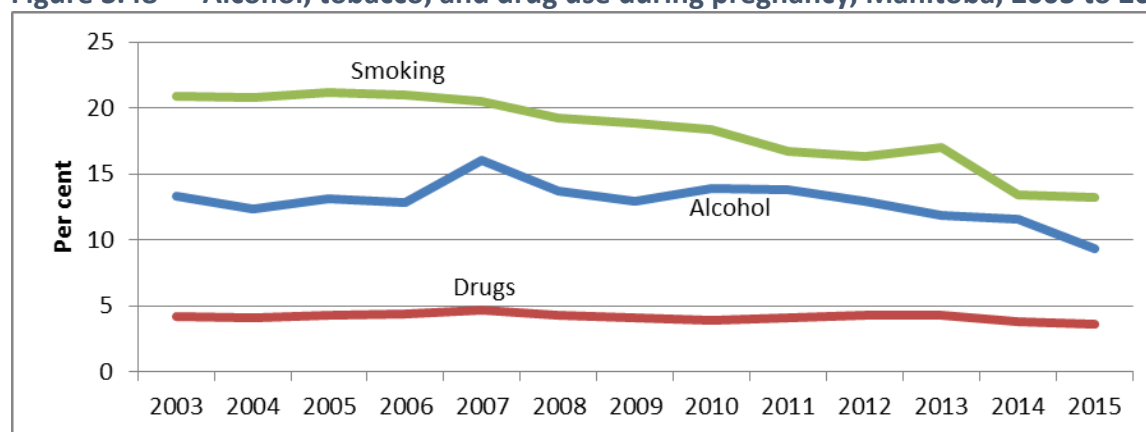
Manitoba was the first jurisdiction in Canada to implement the collection of population-level information on the prevalence of maternal alcohol use during pregnancy. Public health nurses in Manitoba visit most mothers of newborns (approximately 84%) to see how they are doing.



During this visit, they ask a number of questions about pregnancy and birth using a questionnaire called the Families First Screen.

According to information from the Families First Screen, the percentage of women reporting that they consumed alcohol at some point during pregnancy has fluctuated between 2003 and 2015. However, since 2010 it appears that the percentage is declining, from 14% in 2010 to 9% in 2015 (Figure 3.48). According to recent research, younger women were more likely to consume alcohol during pregnancy than older women, women living in lower-income communities were more likely to consume alcohol than those in higher-income communities and women with less than high school education were more likely to consume alcohol than those with at least a Grade 12 education.<sup>40,46</sup>

**Figure 3.48 Alcohol, tobacco, and drug use during pregnancy, Manitoba, 2003 to 2015**



Source: Families First Screen, Healthy Child Manitoba Office

Note: Excludes new parents who gave birth living in First Nations Communities.

Both illicit and licit drug use during pregnancy can affect the physical and mental health, development and well-being of the developing fetus and infant.<sup>47</sup> The percentage of new mothers reporting drug use during their pregnancy has been relatively low and stable in Manitoba, at around 4% (Figure 3.48). Recent research has indicated that women who are younger, socially isolated, living in lower-income communities and have not completed Grade 12 are more likely to use drugs during pregnancy. In addition, the rates of drug use during pregnancy differ by region and community area.<sup>40,46</sup>

### 3.2.3 Tobacco Use During Pregnancy

There are adverse health effects for both the pregnant woman and fetus associated with smoking during pregnancy. As well as the negative effects on the mother's health, smoking during pregnancy can cause pregnancy complications, including problems with the placenta due to constriction of the blood vessels, miscarriage, stillbirth, and preterm birth. Smoking during pregnancy can negatively affect the development of the fetus and can have long-term negative effects on the physical health and development of the infant, including sudden infant death syndrome (SIDS), inattention and attention deficit/hyperactivity disorder, asthma, and some childhood cancers, including leukemia. The amount and duration of smoking is important, and those who smoke throughout pregnancy are at a higher risk of negative outcomes.<sup>47</sup>

Between 2003 and 2015, smoking during pregnancy declined from 21% to 13% of pregnant women in Manitoba (Figure 3.48). Recent research indicates that the rate of smoking during pregnancy is higher in Manitoba than in Canada overall.<sup>48</sup> Smoking rates during pregnancy are higher among women from vulnerable populations. Pregnant women who are younger, and who have lower levels of education and income are more likely to smoke during pregnancy.<sup>40,46</sup> A study conducted in Manitoba found that smoking during pregnancy was more common among women who had inadequate prenatal care, had low support from others, were not married, and self-identified as First Nations or Métis.<sup>49</sup>

### **3.3 Social and Emotional Health During Pregnancy**

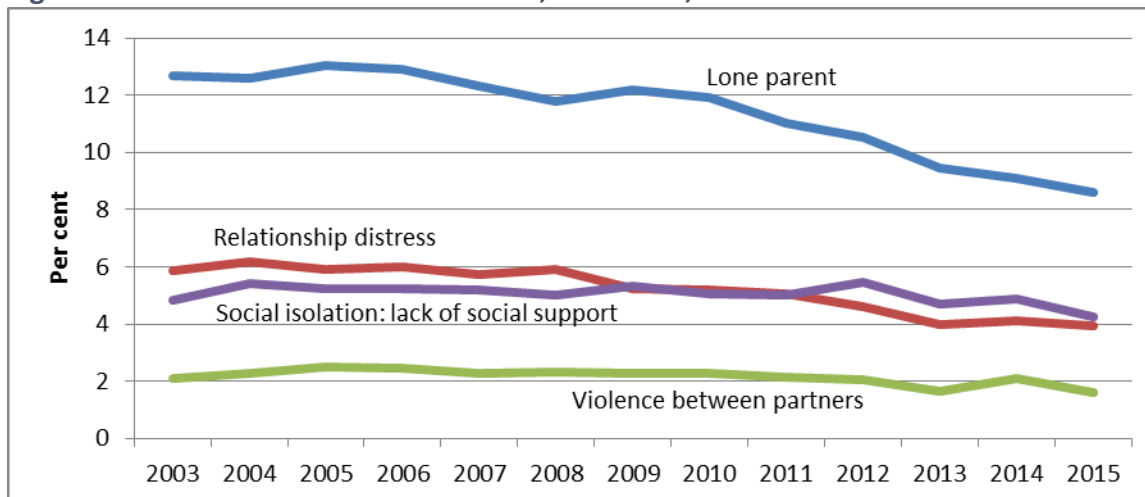
The social and emotional health of the parents and the family are important determinants of their own well-being and the health of their newborns.<sup>50</sup> Supportive families and communities are key to reducing the risk of adverse issues.

#### **3.3.1 Stress**

Pregnancy involves many changes. Some are welcome and some can cause new stress in the lives of expectant parents. While feeling stressed is common during pregnancy, and regular stress can be helpful, high levels of persistent stress can cause complications such as high blood pressure, preterm birth, or low birth weight. While the effects of stress on pregnancy are not yet fully understood, certain stress-related hormones may cause pregnancy complications and serious or long-lasting stress may affect the mother's immune system. Research has also indicated that high levels of stress in pregnancy are associated with attention problems and anxiety among children. Stress also affects the brain development or immune system of the fetus.<sup>51</sup>

One source of stress for pregnant parents is relationship distress. The percentage of mothers in Manitoba reporting relationship distress has declined from 6% in 2003 to 4% in 2015 (Figure 3.49). Abuse (including physical, emotional, and sexual abuse) during pregnancy is associated with adverse pregnancy outcomes and poorer maternal and infant health. In Manitoba, 1.6% of pregnant women reported violence in their relationship in 2015 compared to 2.1% in 2003 (Figure 3.49).

**Figure 3.49 Stress and social isolation, Manitoba, 2003 to 2015**



Source: Families First Screen, Healthy Child Manitoba Office  
Note: Excludes new mothers living in First Nations Communities.

### 3.3.2 Social Isolation

Social support is an important determinant of health. Social support has a positive impact on parents' health, birth outcomes and the infant's future health as an adult. It also has protective effects when there are other risk factors.<sup>52</sup> Low social support during pregnancy has been associated with adverse outcomes such as low birth weight, preterm birth and neurodevelopmental problems. These are likely due to the stress response of the mother that results in elevated stress hormones.<sup>52</sup> In addition, low social support can increase the risk of family violence and postpartum depression.<sup>53,54</sup>

The percentage of mothers reporting social isolation (a lack of social support) has been steady and relatively low in Manitoba, 5% to 4% between 2003 and 2015 (Figure 3.49). A Manitoba study found that higher rates of social isolation were reported among women who had less than Grade 12 education, were older (40+), were receiving income assistance, were lone parents, or lived in lower-income areas of the province.<sup>40</sup> Although lone parenthood does not necessarily mean there is a lack of social support, parenting alone can be a potential source of stress. The percentage of lone-parent mothers in Manitoba has decreased, from 13% in 2003 to 9% in 2015 (Figure 3.49).

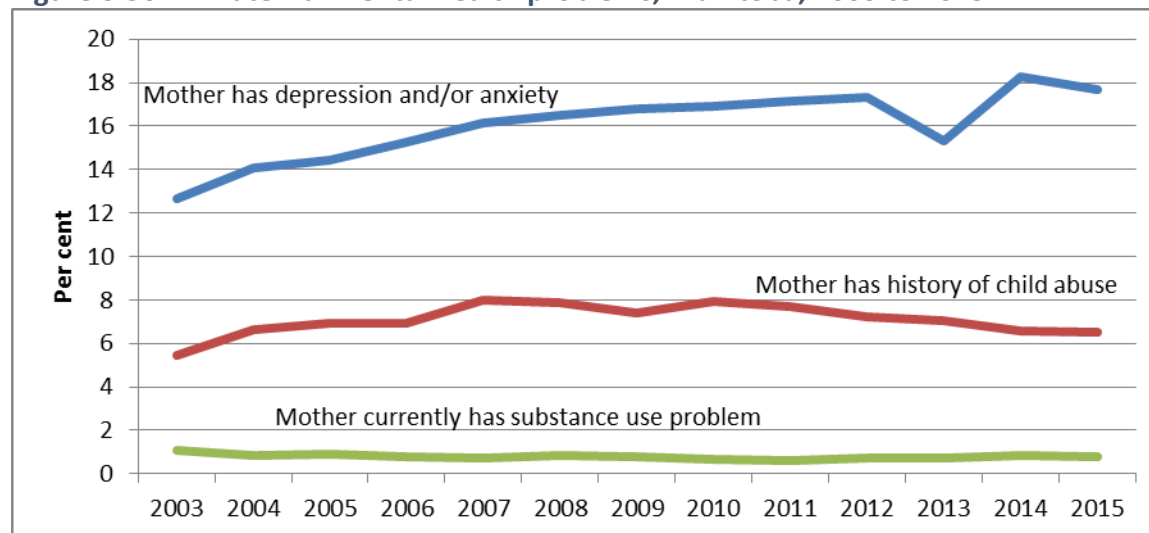
### 3.3.3 Mental Health Problems

Parents can develop mental health problems before, during or after pregnancy. Research reviews indicate that women having mental health problems during pregnancy is one of the main predictors of mental health and development problems in children.<sup>55,56</sup> If women do not receive support and treatment, they can develop chronic symptoms that continue through the postpartum period and beyond.<sup>46,57</sup>

Between 2003 and 2015 in Manitoba, there appears to have been an increase in depression and/or anxiety among pregnant women, from 13% to 18% (Figure 3.50). However, this may be due to increased reporting of mental health issues through the Families First Screen, rather than an increase in depression or anxiety. One factor explaining the increase may be relevant training for public health nurses and increased confidence in addressing mental health issues.

Further, the stigma associated with mental health issues may be declining and more women may be comfortable discussing mental health. The prevalence of self-reported problematic substance use has remained relatively stable at just under 1% (Figure 3.50). The proportion of pregnant women who report that they have experienced abuse as a child has fluctuated between 6% and 8% from 2003 to 2015 (Figure 3.50).

**Figure 3.50 Maternal mental health problems, Manitoba, 2003 to 2015**



Source: Families First Screen, Healthy Child Manitoba Office  
 Note: Excludes new mothers living in First Nations Communities.

### 3.4 Summary

The health and well-being of expectant parents influences the health, well-being and development of their unborn children. There are many influences: social and demographic factors, social and physical environments, relationships and supports, and environmental exposures. These influences can be significant and long term. The social and emotional health of the parents and the family are important determinants of their own well-being and the health of their newborns. Supportive families and communities may mitigate the risk of adverse issues.

- Socioeconomic status is an important factor influencing healthy pregnancies and healthy babies. Higher levels of income and education among parents are associated with better outcomes.
- A mother's nutrition during pregnancy influences her own health and facilitates the healthy development of the fetus. Alcohol, tobacco and other drug use during pregnancy can have adverse outcomes for the infant, developing child and beyond into adulthood.
- When women have mental health problems during pregnancy their children are at increased risk of having mental health and development problems.
- Most Manitoba mothers (78%) give birth in young adulthood (ages 20-34), similar to across Canada. Manitoba has a larger proportion of younger mothers (ages 15-19), while Canada has a larger proportion of older mothers (age 35+).
- Teen pregnancy and birth rates continue to decline over time in Manitoba and remain higher in northern Manitoba and lower in southern Manitoba.

- Fewer babies (off-reserve) are being born into socioeconomic hardship over time. For instance, more mothers have a high school education (85% in 2015 compared to 78% in 2003) and family's financial difficulties decreased from 18% in 2003 to 14% in 2015.
- However, fewer women in inner city Winnipeg and northern Manitoba, where needs are greater, are accessing prenatal care over time.
- Alcohol use, smoking, and relationship distress during pregnancy are all declining over time in Manitoba. However, maternal depression and/or anxiety are on the rise.
  - Alcohol use decreased from 14% in 2003 to 10% in 2015
  - Smoking during pregnancy decreased from 21% in 2003 to 13% in 2015
  - Relationship distress decreased from 6% in 2003 to 4 in 2015%
  - Depression and anxiety increased from 13% in 2003 to 18% in 2015
- Fetal alcohol spectrum disorder (FASD) is referred to as an “invisible disability” because the majority of people with FASD do not have the associated facial features.
- Whether or not alcohol exposure leads to FASD depends on a set of biological and social factors that interact in different ways for each person. Biological factors can include a woman's sensitivity to alcohol, metabolism, and size. Social factors like chronic stress, violence, trauma, or poverty can increase the chances that a baby might be born with FASD.

## Chapter 4. Early Childhood (Birth to Age 5 Years)

A remarkable amount of physical growth and change occurs in early childhood. Bones lengthen and harden, and muscles strengthen. The brain is also undergoing an extended and intense period of development: The dramatic growth in size and sophistication of a baby's brain is a process that begins in the womb and continues after birth. This is the most rapid period of brain development in one's lifetime. From birth to the age of 5, brain development is concentrated primarily in areas such as vision, hearing, language, and other mental processes.<sup>58</sup>

In early childhood, brain development is very sensitive and responsive to all stimuli, both positive and negative. Experiences build the architecture of the brain, with young children 'absorbing' experiences from the social world.<sup>59</sup> Scientists refer to this period as a time of "high plasticity", meaning that the brain is highly flexible and adaptable, depending on its stimulation. With this plasticity comes vulnerability, and as a result, children show a great deal of variation in their development.<sup>60</sup> Children who grow up in an enriched environment will develop more brain connections. This "serve and return" process shapes the circuitry of babies' brains, which may have subtle but long-term effects on children's later development.<sup>58</sup> The most important early social relationship is when an infant bonds with their primary caregivers. Called attachment, early bonds form over a series of many interactions and the life circumstances of the family (financial security, parental mental health, relationships, etc.) can promote or disrupt attachment and either helping the child to develop a sense of security, or conversely fostering a sense of insecurity.<sup>61,62,63</sup> In any case, the attachment bond affects how children develop socially and emotionally, and form social relationships later in life. The more secure the attachment is in infancy, the more likely the child is to form stable, secure relationships as an adult.<sup>64,65</sup>

During the early years, child development is highly dependent on the social and physical environment. Toxic stressors (such as poverty, child maltreatment, and family violence) derail the healthy development of the brain. The family's social and emotional environment is an important contributing factor to the child's physical and emotional well-being. A stable home and secure community with access to basic requirements (such as housing and food) and freedom from physical and emotional harms is crucial for proper brain development and the best possible start in life. This security allows children to engage in the world inside and outside of the family and develop important social skills such as empathy, cooperation and sharing, and control over emotions. As children become more physically mobile and social, there are physical risks of accidents and injuries. Physical safety and security include appropriate parental care, safe homes, and safe neighbourhoods, including safe places to play.

The early childhood period builds from the foundation established in the prenatal period. As discussed in *Chapter 3. Prenatal*, mothers who have adequate nutrition, good social support systems, and access to prenatal care tend to have healthier babies. Once babies are born, healthy social and physical environments are important to ensure healthy child development. Developmental delays in physical, learning, or behavioural skills typically result in problems later on in school.<sup>66</sup> Children's paths are not set in stone, however, and children vary in their response to both positive and adverse childhood experiences.<sup>59</sup> Children can show amazing resilience, and later influences and supports that encourage healthy development can help

children to flourish.<sup>3</sup> Early interventions can reduce risk factors and enhance protective factors that affect children's development. Assessments that identify delays in development, and interventions implemented in a timely manner, are essential to promoting child health. Because child development is linked to broad factors such as nutrition, poverty and neighbourhood safety<sup>67</sup> and is especially sensitive to the effects of stress,<sup>68</sup> attention to these determinants is important to the well-being of Manitoba's children.

## **4.1 Physically Healthy**

### **4.1.1 Birth Outcomes**

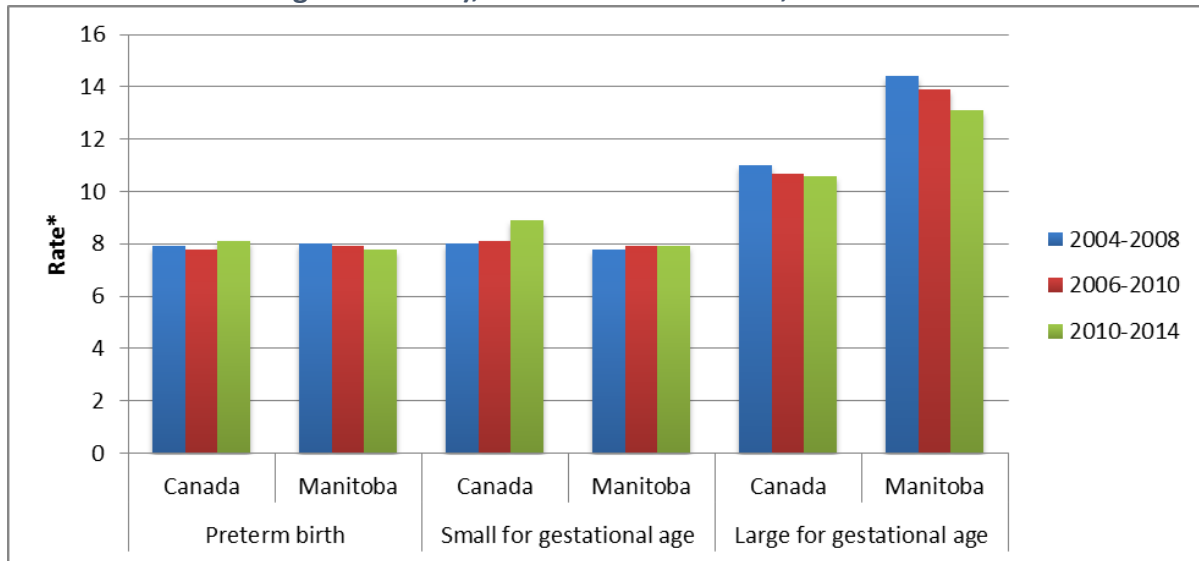
The health of newborns can tell us a lot about the overall health of Manitobans and help predict the likelihood of several adult health concerns. The majority of babies in Manitoba are born healthy. However, for those that are born with problems, the consequences can be serious, tend to occur more often in lower socioeconomic families, and are often preventable.<sup>69</sup>

Preterm births<sup>70</sup> remain a leading cause of death and disability among newborns and infants,<sup>71</sup> Typically, preterm infants are low birth weight (LBW)<sup>72</sup> although not all LBW infants are preterm.

An infant's growth during pregnancy are also important in predicting the likelihood of positive outcomes. Two commonly used measures are small-for-gestational-age (SGA) and large-for-gestational age (LGA). SGA births are associated with increased fetal and infant illness and death, and low birth weight. Accelerated fetal growth can result in birth complications for both the infant and the mother. In turn, high birth weight may increase the risk of type-2 diabetes later in a child's life. LGA births are more common among First Nations women, particularly those with gestational diabetes.<sup>73</sup>

In Manitoba, the preterm birth rate was stable between 2004-2008 and 2010-2014, and comparable to the Canadian rate. The rate of SGA remained stable in Manitoba, while it rose in Canada and in 2010-2014 Manitoba's SGA rate was lower than in Canada overall. The LGA rates in Manitoba remained higher than in Canada despite a drop in LGA rates in Manitoba between 2004-2008 and 2010-2014 (Figure 4.51).

**Figure 4.51 Rate of preterm births (number per 100 live births), small-for-gestational-age (number per 100 singleton births) and large-for-gestational age (number per 100 singleton births), Manitoba and Canada, 2004 to 2014**



\*Rate of preterm: number per 100 live births. Rate of small-for-gestational-age and large-for-gestational age: number per 100 singleton births. Sources: Public Health Agency of Canada. Perinatal Health indicators for Canada 2017. A Report from the Canadian Perinatal Surveillance System. Perinatal Health indicators for Canada 2011. A Report from the Canadian Perinatal Surveillance System. Ottawa, ON: Public Health Agency of Canada.

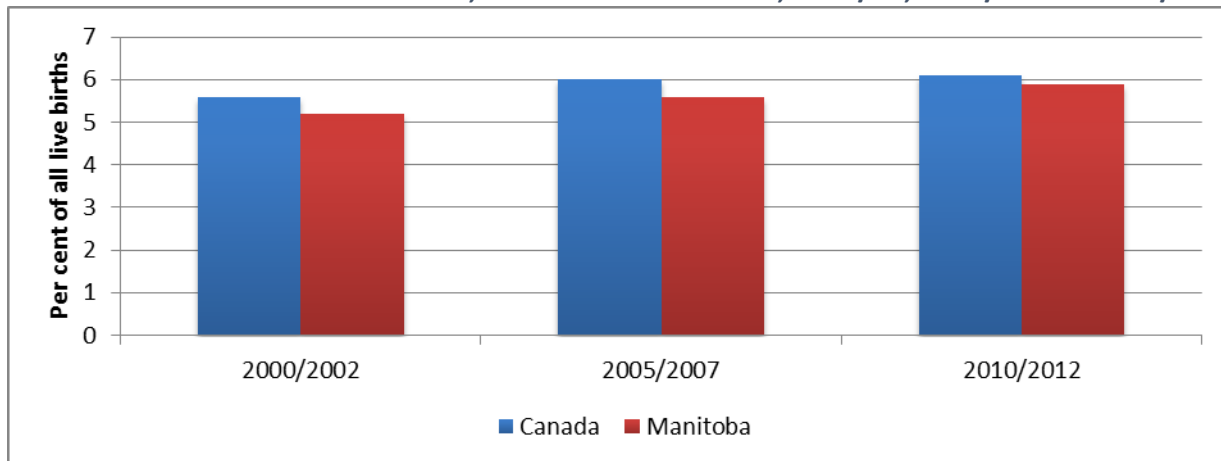
Notes: 2010-2014 data: Data for Québec were excluded because they do not contribute to Canadian Institute for Health information (CIHI) Discharge Abstract Database (DAD). 2004-2008 data: Data for Ontario were excluded because of data quality concerns. Preterm birth rate: Excludes live births with unknown gestational age. Small-for-gestational-age rate (SGA) 2010-2014: Excludes live births with unknown gestational age or birth weight, live births with gestational age <22 weeks or >43 weeks, and multiple births. SGA cut-off is based on the 10th percentile of the sex-specific birth weight for gestational age. Data for Québec were excluded because they do not contribute to CIHI-DAD. SGA rate 2004-2008: Data from Ontario were excluded because of data quality concerns. Excludes live births with unknown gestational age or birth weight, live births with gestational age is based on the 10th percentile of the sex-specific birth weight for gestational age. Large-for-gestational age (LGA) rate 2010-2014: Excludes live births with unknown gestational age or birth weight, live births with gestational age <22 weeks or >43 weeks, and multiple births. LGA cut-off is based on the 90th percentile of the sex-specific birth weight for gestational age. Data for Québec were excluded because they do not contribute to CIHI-DAD. Large-for-gestational age rate 2004-2008: Data from Ontario were excluded because of data quality concerns. Excludes live births with unknown gestational age or birth weight, live births with gestational age <22 weeks or >43 weeks, and multiple births. LGA cut-off is based on the 90th percentile of the sex-specific birth weight for gestational age.

LBW is a very important health measure because it is associated with a wide range of health problems across the life course. The lower the birth weight, the higher the risk of significant and lasting learning problems.<sup>74</sup> LBW has been associated with chronic disease in adulthood, including heart disease and type-2 diabetes.<sup>75</sup> Income is a factor in the likelihood of low birth weight, as well as the risk of poorer outcomes from LBW. A Canadian study found that the LBW rate was 43% higher in the poorest income quintile than in the richest quintile area.<sup>76</sup> LBW children born into low socioeconomic families were at higher risk for lasting complications than those born into families with more resources.<sup>77</sup>

The LBW rate increased slightly in Manitoba between 2000/02 and 2010/12. It was comparable to the Canadian rate in 2010/12 (Figure 4.52).



**Figure 4.52 Low birth weight rate (live births weighing lower than 2,500 grams) as a per cent of all live births, Manitoba and Canada, 2000/02, 2005/07 and 2010/12**



Source: Statistics Canada. Table 102-4317 - Birth-related indicators (low and high birth weight, small and large-for-gestational age, preterm births), by sex, three-year average, Canada, provinces, territories, health regions and peer groups, occasional (number unless otherwise noted)  
 Note: LBW rate is live births with a birth weight less than 2,500 grams, expressed as a percentage of all live births (birth weight known).

#### 4.1.2 Nutrition

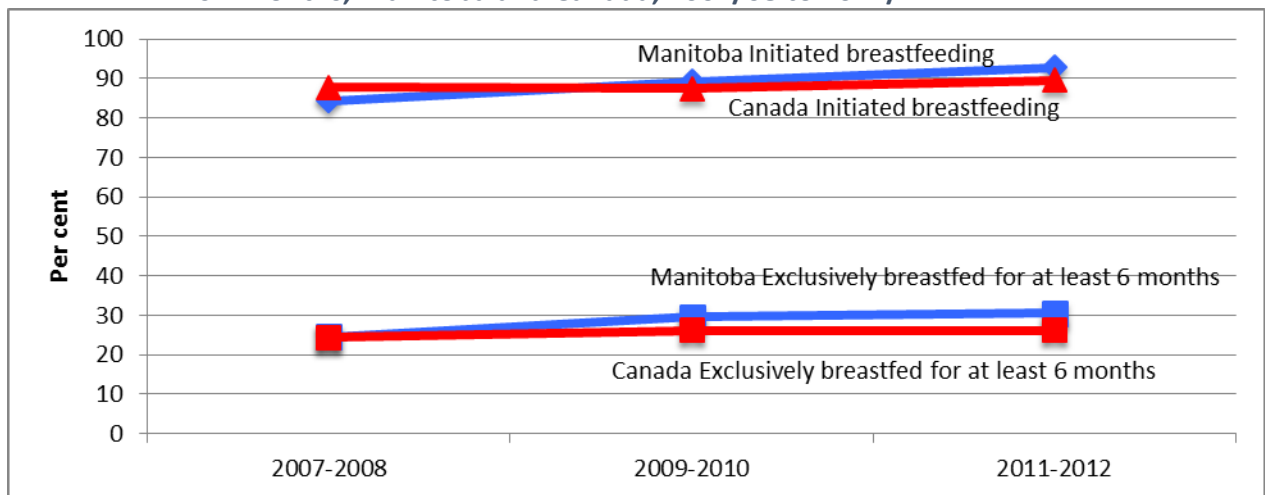
Nutrition is important to child development. Poor nutrition in childhood, including mild undernutrition and micronutrient malnutrition (shortage of vitamins and/or minerals), can alter children’s development both physically and mentally. Conditions such as iron deficiency anemia can affect children’s physical development as well as their school achievement. Malnutrition may have lifelong effects, resulting in an increased risk of chronic conditions in later life, including arteriosclerosis, some cancers, osteoporosis and diabetes.<sup>78</sup>

Experts recommend that mothers breastfeed exclusively up to 6 months of age.<sup>79</sup> The benefits of breastfeeding for children are numerous, including a reduction in ear infections, skin conditions, gastrointestinal and respiratory infections, and reduced incidence of asthma and leukemia.<sup>80</sup> Children who are exclusively breastfed up to and beyond 6 months of age had lower rates of illness when compared to those who ‘weaned’ or used mixed feeding methods at three or four months.

Breastfeeding is encouraged for its potential health benefits to mothers because it is associated with lower rates of type-2 diabetes and cardiovascular disease, as well as lower rates of breast and ovarian cancers.<sup>81</sup>

The majority of Manitoba mothers initiate breastfeeding and this rate has increased from 84% in 2007/08 to 93% in 2011/12, higher than the Canadian rate of 90%. The rate of exclusive breastfeeding, for at least six months, in Manitoba increased from 25% in 2007/08 to 31% in 2011/12 and is higher than the Canadian rate of 26% (Figure 4.53).

**Figure 4.53 Per cent of mothers initiating breastfeeding and exclusively breastfeeding at six months, Manitoba and Canada, 2007/08 to 2011/12**



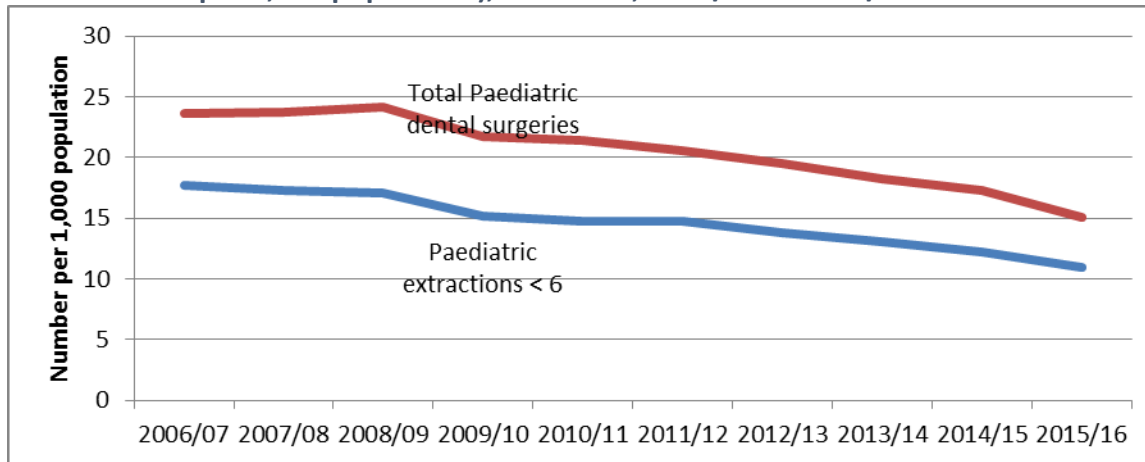
Source: Canadian Community Health Survey 2007-2008; 2009-2010; 2011-2012, Public Use Data Set, Accessed through <ODESI> data portal on September 11, 2017

### 4.1.3 Oral Health

Oral health is an important part of children’s well-being. Children with extreme tooth decay experience pain that may affect their sleep, behaviour, and social interaction. They have also found that children with extreme tooth decay may be at risk for malnutrition.<sup>82,83,84</sup> Children with tooth decay at an early age are those that continue to have negative dental issues in adulthood; hence the concern is not only with the state of the first set of teeth, but oral health thereafter.<sup>85</sup> Children from disadvantaged communities have higher rates of tooth decay and are more likely to undergo dental surgery.<sup>85</sup> Higher rates of extraction associated with lower-income areas may be due to a number of factors, including poorer nutrition, lack of access to appropriate preventive dental care, lack of dental insurance, and bottle feeding.<sup>86</sup> Dental health care is not included in the Canadian Health Act and therefore, it is not part of universal health care in Manitoba.

One indicator of poor oral health is pediatric dental extraction, which is the removal of one or more teeth, usually due to severe decay. Manitoba pediatric dental surgeries are one of the most common surgeries performed at pediatric surgical facilities in Canada. Over 2300 children in Manitoba undergo dental surgery under general anesthetic in hospital each year with more undergoing surgery in private facilities.<sup>85</sup> Between the periods 2006/07 and 2015/16, the rate of pediatric (ages 0 to 5) dental surgeries in hospital in Manitoba decreased, as did the dental extraction rate. In 2015/16, the pediatric dental extraction rate for Manitoba was 11 per 1,000 children under 6, down from 18 in 2006/07 (Figure 4.54).

**Figure 4.54** Rate of dental extractions among children under 6 years (number per 1,000 population) and rate of dental surgery among children under 6 years (number per 1,000 population), Manitoba, 2006/07 to 2015/16



Source: Manitoba Health, Seniors and Active Living, Annual Statistics 2015-2016  
<https://www.gov.mb.ca/health/annstats/as1516.pdf> (Accessed July 24, 2017)

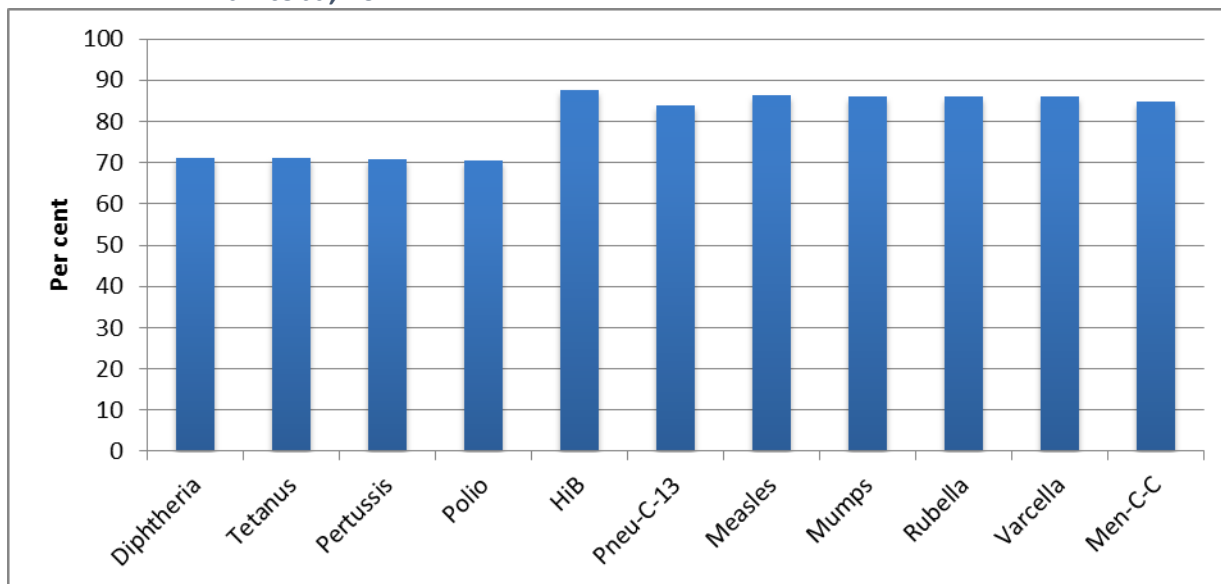
#### 4.1.4 Immunization

Over the past 50 years, immunization has saved more lives in Canada than any other health intervention.<sup>87</sup> However, public health systems continue to face challenges to the effective implementation of immunization schedules. Among these challenges are the growing complexity of schedules (i.e., more injections and new vaccines), and public misunderstandings about vaccines and infectious diseases.

The Canadian Immunization Guide schedule provides guidelines to protect against vaccine-preventable diseases. The Manitoban schedule recommends vaccinations for children between the ages of two months and 2 years of age with boosters and flu vaccine. Vaccination rates in Manitoba depend on the specific vaccine: the highest coverage rates were for Haemophilus Influenza Type b (88%) and the lowest were for diphtheria, tetanus and pertussis (71%) and polio (70%) (Figure 4.55). The rates for most vaccines were consistent between 2010 and 2014 except for polio, which has decreased and Haemophilus Influenza Type b, Pneumococcal conjugate 13 and varicella, which have all increased.<sup>88</sup> Some populations have lower immunization rates: Children born to low-income families, First Nations families, or teen-aged mothers are less likely to receive the full complement of recommended immunizations.<sup>89,90</sup>

In Manitoba, the average number of children hospitalized for vaccine-preventable diseases (VPDs) decreased from an average of 0.19 per 1,000 children (1996 to 2001) to 0.08 per 1,000 children (2001 to 2006).<sup>89</sup> Of children hospitalized for VPDs, 80% were under 5 years old and 60% were infants. Nearly 50% of vaccine-preventable hospitalizations between 1996/97 and 2005/06 were due to pertussis (whooping cough). Higher rates of vaccine-preventable hospitalizations were found in lower-income areas. Not surprisingly, regions with lower immunization rates had higher rates of hospitalizations for VPDs.<sup>89</sup>

**Figure 4.55 Per cent of 2-year-olds who have had the recommended immunization, Manitoba, 2014**



Source: Manitoba Immunization Monitoring System Annual Report 2014.

<http://www.gov.mb.ca/health/publichealth/surveillance/mims/index.html> (Accessed July 24, 2017)

Notes: Pneu-C-13 = Pneumococcal conjugate 13 vaccine. Men C-C = Meningococcal conjugate C vaccine. HiB = Haemophilus Influenza Type b.

### **The Early Development Instrument (EDI)**

The EDI is a teacher-completed questionnaire that measures Kindergarten children’s readiness for school across several areas of child development, compared to children in other communities or provinces. The EDI is used to help communities identify their strengths and needs so they can best support early childhood development. The EDI tells us how ready children are for school in the following areas of child development:

- physical health and well-being
- social competence
- emotional maturity
- language and thinking skills
- communication skills and general knowledge

The best possible score in each area is 10. ‘Very Ready’ results reflect the proportion of children whose scores fall within the top 30th percentile of EDI scores. ‘Not Ready’ results reflect the proportion of children whose scores fall within the bottom 10th percentile of EDI scores. The Very Ready and Not Ready results have been derived using Canadian standardized cut-off scores. Achieving “school readiness” is one of the most important developmental goals for children before the age of 5. Extensive evidence illustrates that readiness for school is a powerful predictor of later success in school.

Source: Santos, R., Brownell, M., Okechukwu, E., Mayer, T., & Soodeen, R.A. (2012). *The Early Development Instrument in Manitoba: Linking socioeconomic adversity and biological vulnerability at birth to children’s outcomes at age 5*. Winnipeg, MB: Manitoba Centre for Health Policy

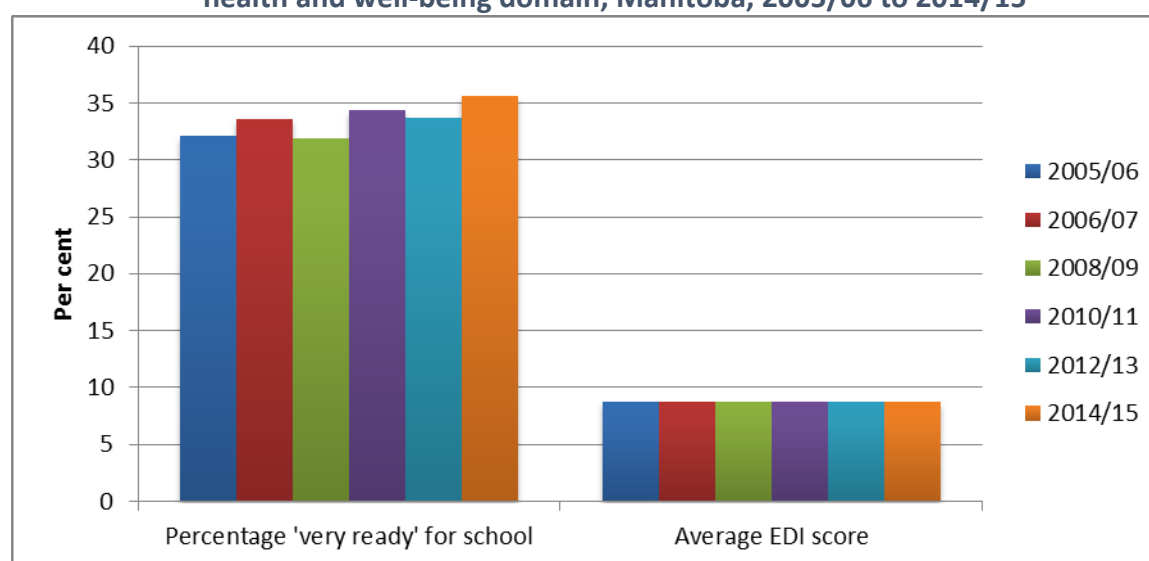
#### **4.1.5 Physical Health and Well-Being**

Between birth and age 5, children are developing a tremendous number of skills –physical, mental, social, and emotional - that prepare them for their entry into school. The EDI is an important tool in assessing school readiness.<sup>91,92,93</sup> Children who are physically ready to learn (appropriately fed, rested, and dressed), and at the appropriate level of independence and motor skill development are more likely to succeed at school.

Between 2005/06 and 2014/15, Manitoba’s average EDI scores on physical health and well-being were stable, ranging from 8.7 to 8.8, and Manitoba’s baseline average score was not different from the Canadian baseline average score of 8.8. In terms of “very ready for school,” Manitoba results for physical health and well-being improved, from 32% to 36%, and the percentage of children in Manitoba who were “very ready” did not differ from the Canadian baseline average of 34% (Figure 4.56).

Girls had higher average scores on physical health and well-being domain than did boys. Indigenous (First Nations, Métis and Inuit) children had lower average scores than non-Indigenous children.<sup>94</sup>

**Figure 4.56 Per cent of children who are very ready for school according to the physical health and well-being domain of the EDI and average EDI score on the physical health and well-being domain, Manitoba, 2005/06 to 2014/15**



Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report. [https://www.gov.mb.ca/healthychild/edi/edi\\_reports.html](https://www.gov.mb.ca/healthychild/edi/edi_reports.html). Accessed September 20, 2017

Notes: The Canadian EDI baseline is from a national representative subgroup of the EDI collected over the years 2004/05, 2005/06 and 2006/07. This represents about 53% of all Kindergarten children in Canada. The Canadian baseline is used to compare to Manitoba scores over three years of data collection. 2005/06 was the first year that all 37 school divisions in Manitoba participated and then in 2006/07 and thereafter, data was collected biennially. This domain measures physical readiness, are the children dressed appropriately for the weather, do they come to school late, hungry and/or tired; physical independence, have they developed the skills of independence, handedness, coordination and do they suck their thumb; and gross and fine motor skills, do they have difficulty performing skills requiring gross and fine motor competence, and do they have poor overall energy levels and physical skills.

## 4.2 Mentally Healthy

During the infant and toddler years, a child’s social network is centred on the home. Even when young children spend a great deal of time outside of the home, such as in early childhood education and care settings, parents and caregivers remain the most important influence on children’s lives. Attachment is important in helping children cope with stress and may have long-term implications for children’s emotional and mental health.<sup>95</sup>

Secure attachment tends to occur when caregivers are emotionally available and responsive to the child’s communication, such as picking them up and comforting them when they cry or smiling and talking with them when they smile. Secure and stable relationships strengthen a

child's confidence and self-esteem, allowing them to explore the world with a sense of safety and security.<sup>96,97</sup>

Secure attachment increases the chances of better social relationships later in life<sup>98</sup> and results in children and adults who are more likely to be sociable, empathic, and positive, and less likely to be aggressive later in childhood and as adults.<sup>64</sup> They are also more likely to be responsive parents themselves.<sup>99</sup>

#### **Toxic Stress, Brain Development, and Lifelong Health**

When we get stressed, our bodies respond with increased heart rate, blood pressure, and levels of various hormones such as cortisol. A little bit of stress once in a while can be a positive thing, helping us manage a short-term “fight or flight” response. However, over the long term, stress hormones can literally be toxic.

Persistent high levels of traumatic stress, called toxic stress, can result from insecure environments such as family conflict, violence, neglect, unhealthy living conditions, or hunger. Children from lower socioeconomic backgrounds are more likely to show heightened activation of stress response systems.

Toxic stress can cause serious damage to a developing brain and influence the development of parts of the brain that control abilities such as planning and reasoning. This can lead to impaired judgment, memory, attention, and self-control, and a weakened immune system.

Toxic stress in childhood can have severe and lifelong consequences, increasing the chances of developing chronic diseases such as high blood pressure, cardiovascular disease, and diabetes, as well as mental health problems, such as depression or substance abuse, later in life.

Sources: Science of Early Child Development, National Scientific Council, Centre on the Developing Child at Harvard University; Duncan GJ, Magnuson K. (2012). Socioeconomic status and cognitive functioning: Moving from correlation to causation. *WIREs Cogn Sci*, 3:377–386.

#### **4.2.1 Parental and Family Influences**

Relationships are critical to child outcomes, especially relationships with parents and caregivers. Positive parental relationships are associated with a range of things from building brain architecture to helping children build resiliency. The architecture of the brain is strengthened in a serve and return series of interactions with primary caregivers. Positive interactions help build self-regulation. Harsh inconsistent relationships create shaky foundations.

As children grow, parents and parenting style continue to exert a strong influence in child outcomes. Harsh & punitive discipline styles have been associated with antisocial behaviour in children including substance abuse and conflict with the law. Lax parenting that includes inconsistent discipline, poor monitoring and supervision has also been associated with antisocial behaviours in children/youth. Warm supportive parenting with consistent limits and appropriate discipline has been associated with positive outcomes in children.<sup>100</sup>

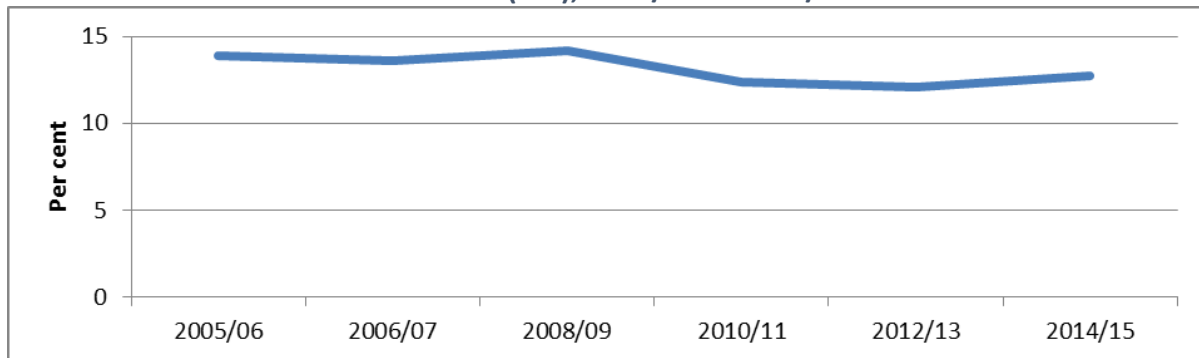
Parenting style and practices have been shown to be highly amenable to change through appropriate evidence-based programs. The provision of these programs has been shown to be highly effective. External factors such as poverty, stress and violence also have a huge impact on parenting style and parent child relationships. Both parenting programs and family supports are important investments in positive outcomes.

## 4.2.2 Hyperactive/Inattentive Behaviour

Emotional and behavioural problems in young children are often detected and diagnosed when they enter school. Early signs of emotional or anxiety disorders and hyperactive/inattentive behaviour can begin to show in early childhood.

The EDI measures hyperactivity, defined as children often showing most of the following indicators: restless, distractible, impulsive; they fidget and have difficulty settling to activities. In 2014/15, 13% of Manitoba children were vulnerable on the hyperactivity sub-domain (Figure 4.57).

**Figure 4.57 Per cent of Manitoba children vulnerable in the hyperactive and inattentive behaviour sub-domain (EDI), 2005/06 to 2014/15**



Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report. [https://www.gov.mb.ca/healthychild/edi/edi\\_1415/2014\\_15\\_edi\\_provincial\\_report.pdf](https://www.gov.mb.ca/healthychild/edi/edi_1415/2014_15_edi_provincial_report.pdf) (Accessed September 19, 2017)

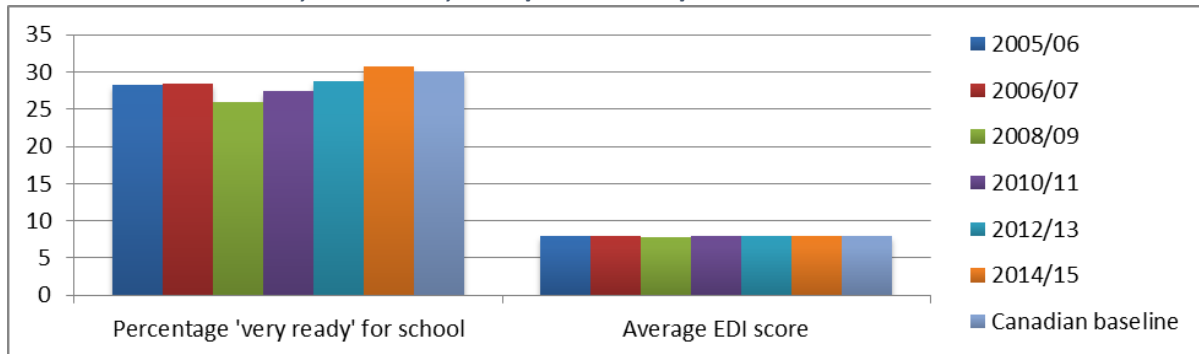
Note: This shows the proportion of children who have met few/none developmental expectations (or, who are considered vulnerable) across the sub-domains.

## 4.2.3 Emotional Maturity

Research has shown that children who score high in emotional maturity are more likely to succeed at school.<sup>101,102</sup> The EDI measures emotional maturity, which includes prosocial and helping behaviour, anxious and fearful behaviour, aggressive behaviour, and hyperactive and inattentive behaviour. The percentage of Manitoba students who were assessed as 'very ready for school' in terms of emotional maturity increased from 28% to 31% between 2005/06 and 2014/15 (Figure 4.58).

Between 2005/06 and 2014/15, Manitoba average EDI scores for emotional maturity were stable, ranging from 7.8 to 8.0 (10 is the best possible score) (Figure 4.58). Girls had higher average scores on the emotional maturity domain than did boys. Children older than 5.6 years scored higher on average than those who were younger than 5.6 years. Children with English as an additional language had lower average scores than children without the additional language. There was no difference in the average scores between children who had recently immigrated and those who have not. Indigenous children had lower average scores than non-Indigenous children.<sup>94</sup>

**Figure 4.58** Per cent of children who are very ready for school according to the emotional maturity domain of the EDI, and average EDI score on the emotional maturity domain, Manitoba, 2005/06 to 2014/15



Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report. [https://www.gov.mb.ca/healthychild/edi/edi\\_1415/2014\\_15\\_edi\\_provincial\\_report.pdf](https://www.gov.mb.ca/healthychild/edi/edi_1415/2014_15_edi_provincial_report.pdf) (Accessed September 19, 2017)

### 4.3 Safe and Secure

One of the things that makes humans unique from other species is how long we remain in childhood, dependent on caregivers for our survival.<sup>103</sup> At birth, the human brain is not yet fully developed, and will not complete development until early adulthood. A safe home and secure community with access to the basic requirements, and freedom from physical and emotional harm, is important for proper brain development and the best possible start in life. The consequences of growing up in a high stress, insecure environment can be lifelong, including mental illness, substance abuse, and increased likelihood for chronic diseases such as high blood pressure and diabetes.<sup>104</sup>

#### 4.3.1 Safety

##### 4.3.1.1 Physical safety: Injury

Despite advances in prevention, injuries remain a leading cause of morbidity and mortality among children. In the 2015 Health Status of Manitobans Report, it was noted that in the last few decades, injury rates have declined across all income levels but lower socioeconomic status was still strongly connected to fatal and serious injuries.<sup>31</sup>

Factors that can increase a child's risk of injury between 1 and 4 years of age include low maternal age and low education level, low income, housing conditions, overcrowding, lack of supervision and inadequate safety precautions.<sup>31</sup>

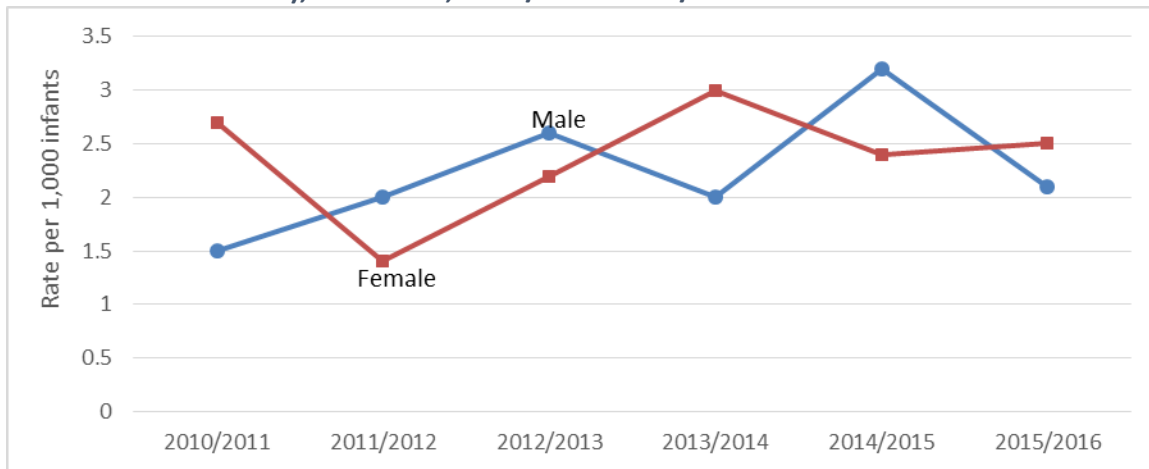
Between the ages of 1 and 4 years, children develop rapidly in terms of cognitive abilities, motor skills and social interaction. Pushing the boundaries of their abilities is an integral part of their learning. Without safeguards in place, children are vulnerable to injury, most frequently due to falls, poisoning, ingesting small foreign objects, and burns.<sup>31,105</sup>

##### *Injury hospitalization*

In 2015/16, the rate of injury-related hospitalizations for infants under 1 year was 2.5 per 1,000 girls and 2.1 per 1,000 boys. From 2010/11 to 2015/16, the rates for boys and girls fluctuated between 1 and 3 per 1,000 (Figure 4.59), with an upward trend for boys over this 5-year period.



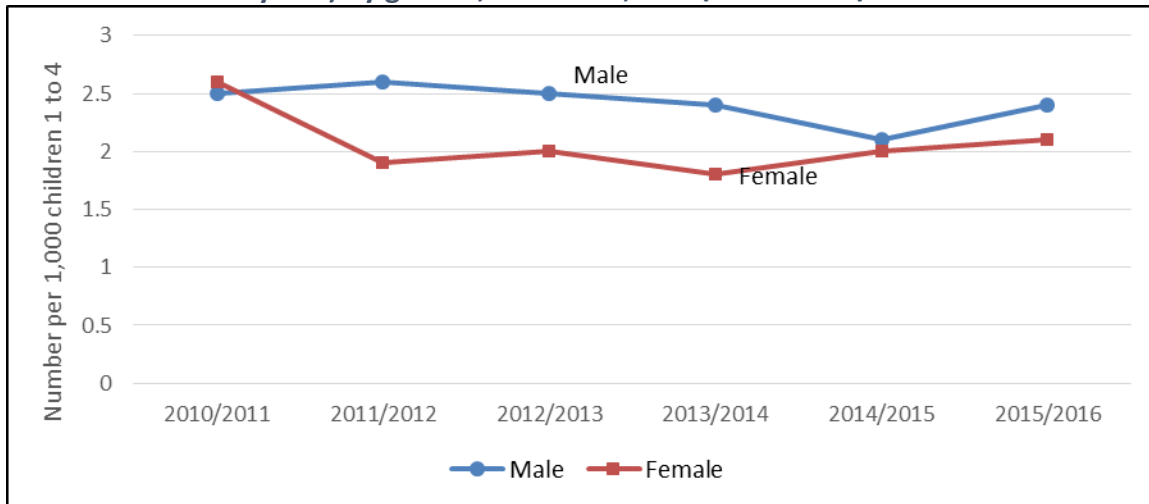
**Figure 4.59** Rate of injury hospitalization, infants under 1 year old, (number per 1,000 infants), Manitoba, 2010/11 to 2015/16



Source: Manitoba Health, Seniors & Active Living Annual Statistics 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015. Retrieved from <http://www.gov.mb.ca/health/annstats/>

In 2015/16, the rate of injury-related hospitalizations for 1- to 4-year-olds was 2.1 per 1,000 for girls and 2.4 per 1,000 for boys. Rates for both girls and boys appear to show a slight downward trend over this 5-year period (Figure 4.60).

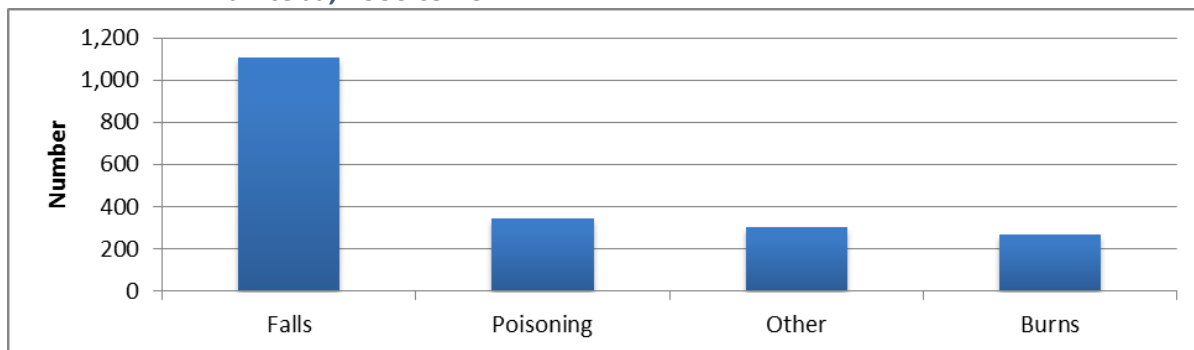
**Figure 4.60** Rate of injury hospitalization, children ages 1 to 4 (number per 1,000 children 1 to 4 years) by gender, Manitoba, 2010/11 to 2015/16



Source: Manitoba Health, Seniors & Active Living Annual Statistics 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015. Retrieved from <http://www.gov.mb.ca/health/annstats/>

Available data identifies the four top causes of injury-related hospitalization for children between birth and age 4 years: falls, poisoning, other causes, and burns (Figure 4.61).

**Figure 4.61** Leading causes of unintentional injury hospitalizations, children ages 0 to 4, Manitoba, 2000 to 2012

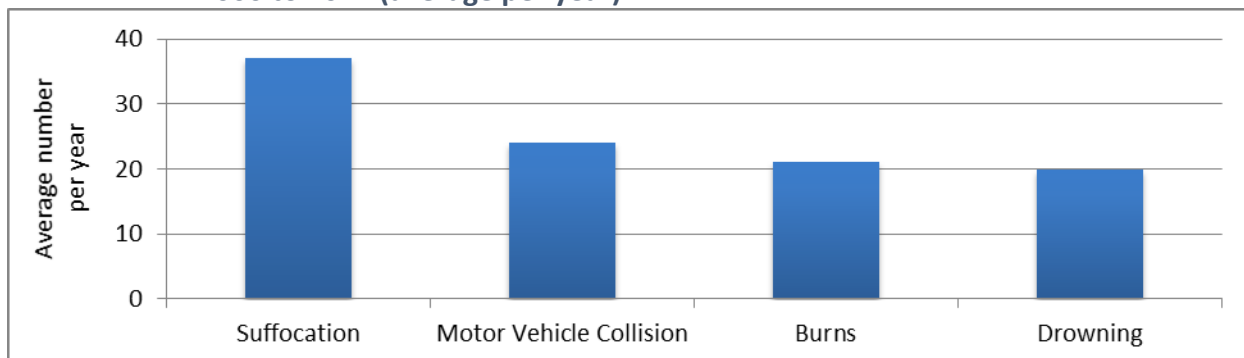


Source: Injury Prevention Plan: Taking Steps to Prevent Injuries in Manitoba, Manitoba Health, Healthy Living and Seniors, June 2015. Retrieved from [https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury\\_prevention\\_plan.pdf](https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury_prevention_plan.pdf) Accessed July 24, 2017

### *Injury death*

The 2015/16 Health Status of Manitobans Report notes that injuries are the leading cause of death for children in Manitoba.<sup>31</sup> The four top causes of unintentional injury death for children between the ages of birth and 5 years (presented as an average per year) were suffocation, motor vehicle collisions, burns and drowning (Figure 4.62).

**Figure 4.62** Leading causes of unintentional injury deaths, children ages 0 to 4, Manitoba, 2000 to 2012 (average per year)



Source: Injury Prevention Plan: Taking Steps to Prevent Injuries in Manitoba, Manitoba Health, Healthy Living and Seniors, June 2015. Retrieved from [https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury\\_prevention\\_plan.pdf](https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury_prevention_plan.pdf)

It is important to distinguish between intentional (e.g., self-inflicted or inflicted by others on purpose) and unintentional causes of injury. There were 21 intentional deaths of children ages 0 to 4 due to assault between 2000-2012: seven infants under a year and 14 children ages 1 to 4.<sup>106</sup> There were 89 infants hospitalized due to assault in the 2000-2012 time period.<sup>106</sup>

#### *4.3.1.2 Physical safety: Infant and child death*

Infant and child death rates are other indicators of safety and security. Historically, infancy (less than one year of age) and early childhood has been a time of great physical risk. Infant mortality is considered to be one of the most sensitive indicators of a nation's health, particularly for the poorest members of a society. The infant mortality rate is sensitive to changes in public policy, particularly those affecting health care and income security.<sup>107</sup>

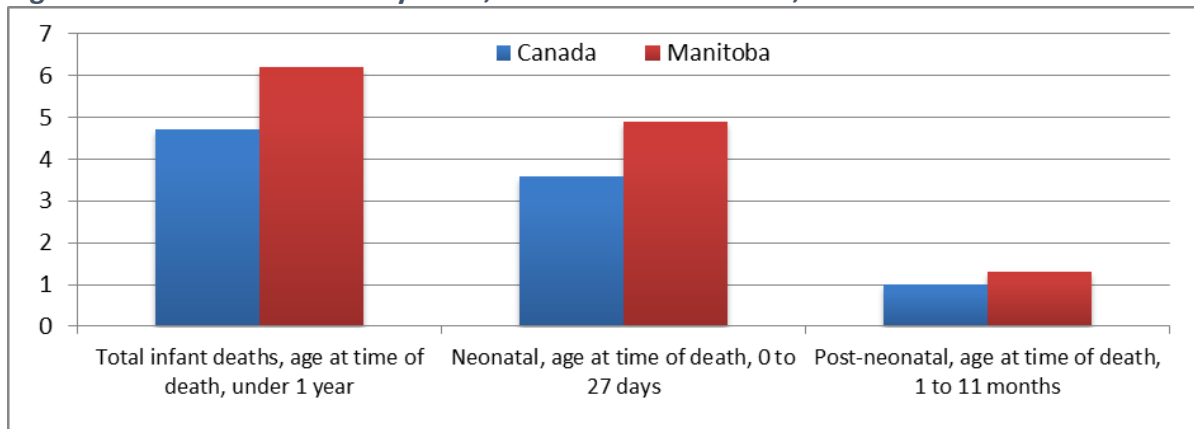
## Infant deaths

Infant mortality rate is one of the most widely used indicators of maternal and child health, and the overall health status of a community. It is strongly related to socioeconomic status, education levels, quality of living conditions and environment, social well-being, health status and health behaviours, and access to and use of health care services, including effectiveness of prenatal care.<sup>108</sup>

Infant mortality is defined as the proportion of live births weighing 500 grams or more with death occurring within 0 to 364 days and is reported as a rate of death per 1,000 live births. Infant mortality can be divided into neonatal mortality (0 to 27 days) and post-neonatal mortality (28 to 364 days).<sup>109</sup> An infant is most vulnerable during the first few weeks of life and this is reflected in the higher rate of mortality during the neonatal period. The most common causes of death during the neonatal period are preterm birth and congenital anomalies.<sup>40</sup> The most common causes of death during the post-neonatal period are congenital anomalies, sudden infant death syndrome (SIDS), and injury. The latter raises issues about the challenges faced by parents after they bring their infant home.

In 2014, Statistics Canada reported the Canadian infant mortality rate as 4.7 per 1,000 live births and, in Manitoba, 6.2 per 1,000 live births. In 2014, Manitoba's neonatal (0 to 27 days) mortality rate was 4.9 per 1,000 live births, compared with 3.6 in Canada overall. The post-neonatal infant mortality rate in Manitoba was 1.3 per 1,000 live births compared with the Canadian rate of 1.0 per 1,000 live births (Figure 4.63).

**Figure 4.63** Infant mortality rates, Canada and Manitoba, 2014



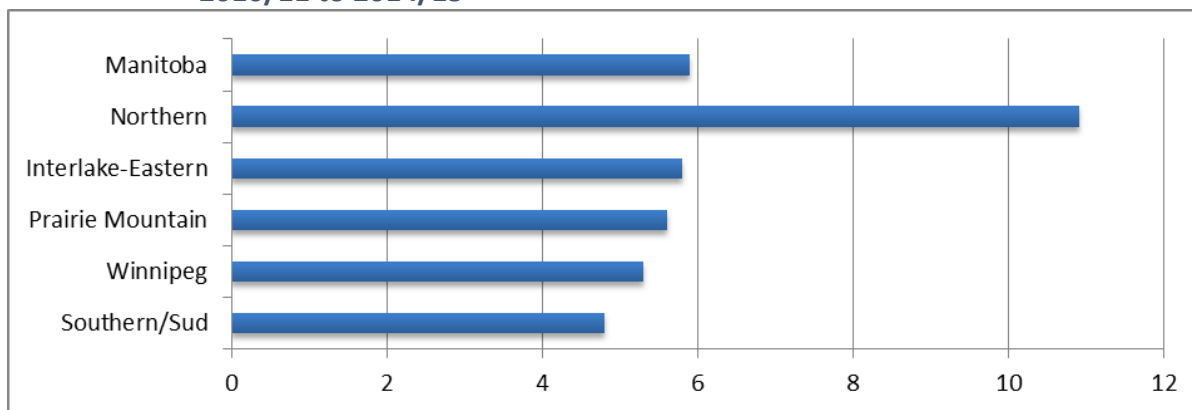
Source: Table 102-0507 Infant deaths and mortality rates, by age group, Canada, provinces and territories, annual. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1020507> (Accessed January 10, 2018)

Notes: Infant death is the death of a child under one year of age; Infant death rate is the number of infant deaths during a given year per 1,000 live births in the same year; Neonatal death is the death of a child under 4 weeks of age (0 to 27 days); Neonatal mortality rate is the number of neonatal deaths during a given year per 1,000 live births in the same year; Post-neonatal death is the death of a child under one year of age but at least 28 days old (28 to 364 days); Post-neonatal mortality rate is the number of post-neonatal deaths during a given year per 1,000 live births in the same year.

More recent data show that, between 2010/11 and 2014/15, Manitoba's overall crude infant mortality rate was 5.9 per 1,000 live births. By Regional Health Authority, the rate of infant deaths ranged from a low of 4.8 per 1,000 live births in the Southern Region and 5.3 per 1,000 live births in Winnipeg, to 5.6 per 1,000 live births in Prairie Mountain and 5.8 per 1,000 live

births in Interlake-Eastern. The Northern Region had the highest infant mortality rate at 10.9 per 1,000 live births, almost double the overall provincial infant mortality rate (Figure 4.64).

**Figure 4.64 Crude rate of infant deaths per 1,000 infants by Regional Health Authority, 2010/11 to 2014/15**

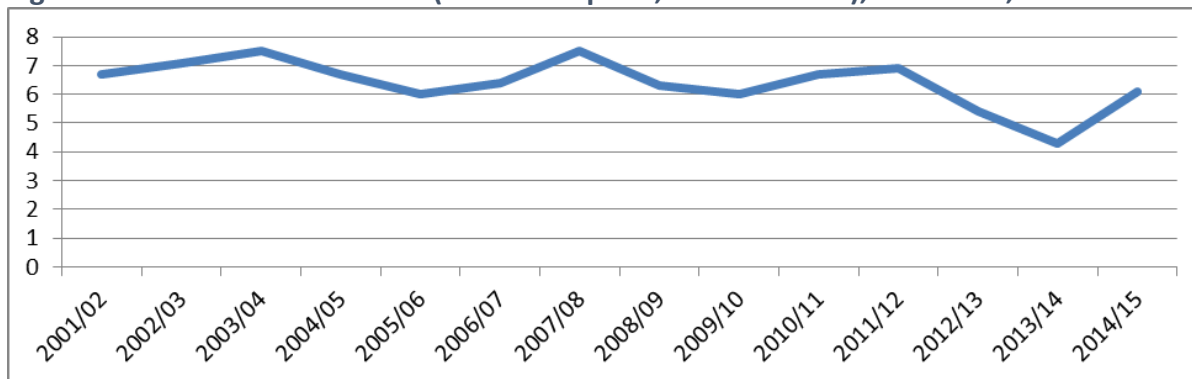


Source: Manitoba Health, Seniors & Active Living Annual Statistics 2015-2016, Population Health Status and Mortality – Infant Mortality, p.19. Infants are defined as individuals less than one year of age.

Notes: Crude death rate is the number of deaths occurring among the population of a given geographical area during a given year(s), per 1,000 mid-year population of the geographical area during the same year(s).

Manitoba’s infant death rate appears to have declined slightly from 2001 to 2015. In 2003/04 and 2007/08, the infant death rate was above 7 deaths per 1,000 live births, and under 6 per 1,000 births in 2005/06, 2009/10 and 2013/14 (Figure 4.65).

**Figure 4.65 Infant death rate (crude rate per 1,000 live births), Manitoba, 2001 to 2015**



Source: Manitoba Government, Health, Seniors and Active Living

The Canadian Institute for Health Information provides a synopsis of the complex interrelated factors that influence maternal health and increase the likelihood of infant mortality.<sup>108</sup> Vulnerability to having an infant die within the first year of their life is associated with a number of factors and the more factors experienced, the greater the risk of infant mortality:

- low income, poor living environments
- having a low level of maternal education
- being a young pregnant or parenting woman
- receiving inadequate prenatal care due to low income, lack of knowledge or remoteness
- experiencing food insecurity
- homelessness / transience
- mental illness during prenatal and postnatal periods

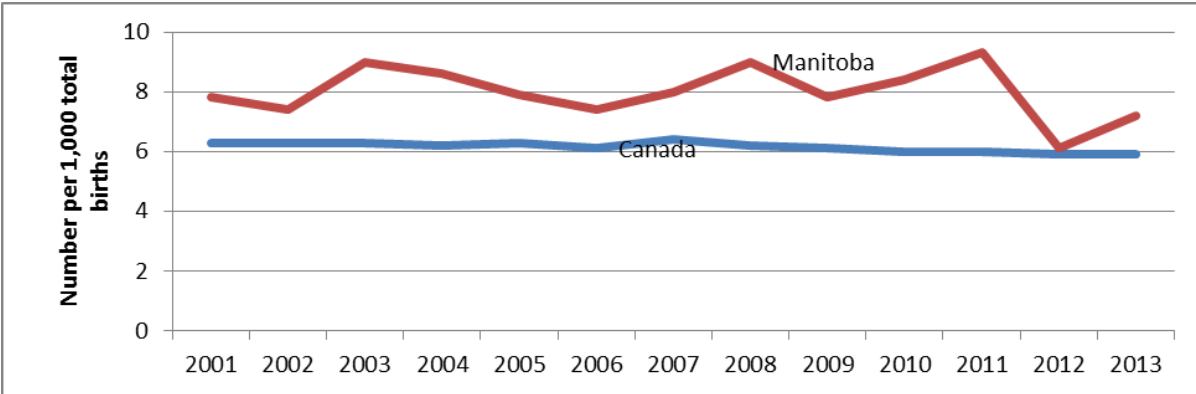
- maternal obesity and diabetes
- smoking during pregnancy, which increases the risk of SIDS
- lack of breastfeeding initiation, with breastfeeding being associated with a reduced risk of SIDS (women in the lowest income quintile are significantly less likely to initiate breastfeeding than mothers in all other income quintiles).<sup>108</sup>

Indigenous women are disproportionately affected by many of these risk factors. For a number of reasons, existing primary population health data sources provide inconsistent, non-inclusive or unreliable Indigenous identity information. Given this, existing data lacks the capacity to disaggregate and provide accurate relevant infant mortality data for First Nations off-reserve, non-status Indigenous peoples, Inuit and Métis peoples.<sup>110</sup> It is noted that, at the national level, the Aboriginal Children’s Survey was not repeated in 2011 resulting in the exclusion of First Nations children between the ages of 0 to 5 from Canada’s Aboriginal specific surveys.<sup>110</sup> There have been supplementary, smaller-scale, peer-reviewed, and generally geographically specific studies that have consistently found Indigenous infant mortality rates to be at least 2 times higher than for the general infant population.<sup>111</sup>

*Perinatal deaths*

Perinatal mortality (stillbirths and early neonatal deaths, before the seventh completed day of life) is considered by many a better indicator than infant mortality in countries with low infant mortality. Perinatal mortality is influenced by such factors as the age of the mother, her health, and her socioeconomic status, as well as gestation and birth weight. In 2013, the perinatal mortality rate in Manitoba was 7 per 1,000 total births, compared to the Canadian rate of 6 per 1000 total births. The perinatal mortality rate in Manitoba has been trending slightly downward between 2001 and 2013 (Figure 4.66).

**Figure 4.66 Perinatal death rate (number per 1,000 total births), Manitoba and Canada, 2001 to 2013**



Sources: Statistics Canada, Canadian Vital Statistics, Birth, Death and Stillbirth Databases  
 Note: Perinatal death is the death of a child under one week of age (0 to 6 days) or a stillbirth of 28 or more weeks of gestation. Perinatal death rate is the number of perinatal deaths during a given year per 1,000 total births (live births plus late fetal deaths) in the same year.

*Deaths among 1- to 4-year-olds*

Very few young children die in Manitoba. In 2013, 21 children ages 1 to 4 died in Manitoba. The provincial mortality rate was 0.2 per 1,000 children ages 1 to 4 in 2013 and fluctuated between 0.2 and 0.3 between 2008 and 2013. The Canadian rate was also 0.2 per 1,000 population in

2013. In Canada, the leading causes of death among 1- to 4-year-olds are unintentional injuries, cancer and congenital conditions.<sup>112</sup>

#### 4.3.1.3 *Safe families*

Infants and young children are completely dependent on others for all of their needs. Parents and caregivers can most directly affect a child's physical safety. Because younger children have a smaller social network (primarily family), they are most at risk of violence from members of their family. In Canada in 2015, of all infants and toddlers under the age of 3 years who were victims of violence, 87% were victimized by someone within their immediate family. The other 13% were victimized by an extended family member.<sup>113</sup>

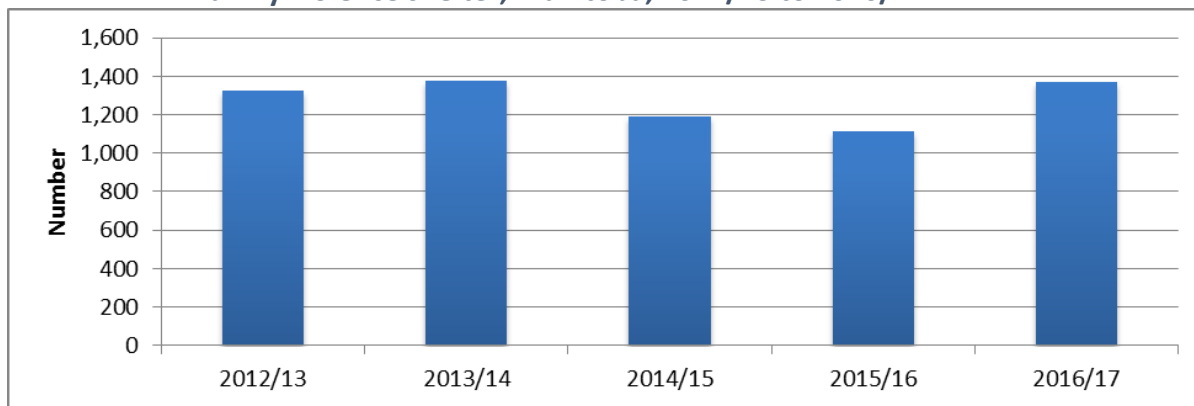
In Canada in 2015, the rate of family violence victimization (reported to the police) among children under 5 years of age was 123 per 100,000 population. The rate was higher for girls (129) than for boys (117). The overall rate in the population was 243 per 100,000 people (aged 0 to 75+ years).<sup>113</sup>

Exposure of a child to family violence can be considered a form of maltreatment that may necessitate investigation, as well as the provision of services and possible removal of children from households. Children's exposure can be direct, which may include seeing or hearing the violence, as well as indirect, such as seeing a parent's injuries or witnessing police intervention. Witnessing spousal violence can result in a range of negative consequences to children, including emotional, psychological, learning, social and behavioural problems, including physical and indirect aggression. Another impact of witnessing violence is the potential intergenerational continuation of violence, meaning that children who have witnessed family violence may become violent in their future families. Research suggests that children in the early stages of development suffer the worst effects of witnessing violence compared to older children, presumably because of their dependency on primary caregivers for all aspects of development. According to the General Social Survey (GSS) on victimization, the proportion of spousal violence witnessed by children in Canada increased from 43% in 2004 to 52% (of spousal violence victims with children) in 2009.<sup>114</sup>

Children are vulnerable when there is domestic violence and require support when there is violence against their mother. The Family Violence Prevention Program of the Manitoba Government funds 37 community-based programs (implemented by 33 agencies) that offer a wide range of programs and services to families affected by family violence, including 10 emergency women's shelters, four residential second stage programs, nine women's resource centres and 14 specialized support programs. Shelters provide emergency accommodation for women and their children for up to 30 days and interim housing units and residential second stage housing programs support women and their children transition toward a violence free life. There are also a number of residential and non-residential support services for children such as individual and group counselling, cultural and educational activities, and access and exchange services.

In 2016/17, 1,371 children and youth under 18 accessed an emergency family violence shelter funded by the Manitoba Government (Figure 4.67). That number fluctuated slightly over the 5 preceding years. (Figure 4.67).

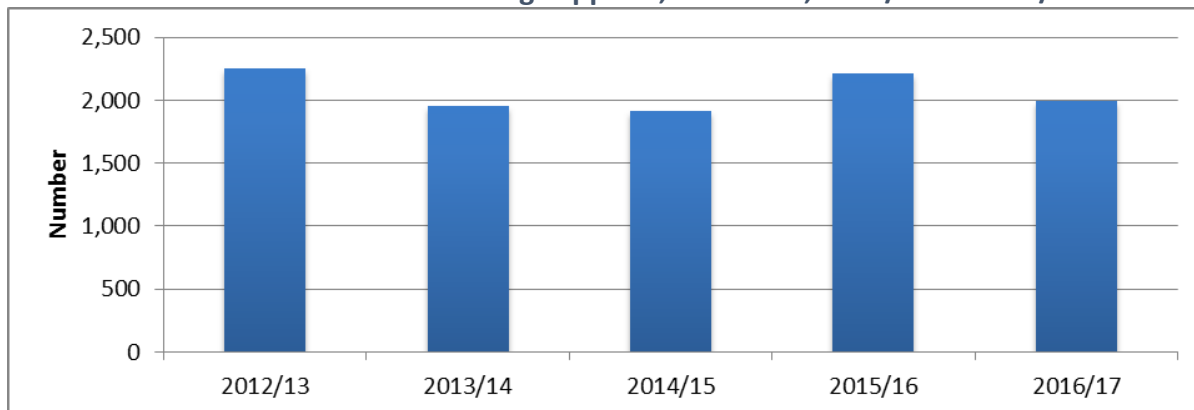
**Figure 4.67** Number of children and youth under 18 years who accessed an emergency family violence shelter, Manitoba, 2012/13 to 2016/17



Source: Family Violence Prevention Program, Manitoba Status of Women Secretariat, Department of Sustainable Development

The number of children and youth who were affected by family violence and who received counselling supports in residential and non-residential facilities that were funded by the Manitoba Government has been around 2,000 between 2012/13 and 2016/17, with a high of 2,252 children and youth in 2012/13 and a low of 1,917 in 2014/15 (Figure 4.68).

**Figure 4.68** Number of children and youth under 18 years affected by family violence and who received counselling supports, Manitoba, 2012/13 to 2016/17



Source: Family Violence Prevention Program, Manitoba Status of Women Secretariat, Department of Sustainable Development

Children with disabilities are at greater risk of maltreatment, including physical, sexual, and emotional abuse, as well as neglect, compared to those who do not have a disability. In a 2006 Manitoba government report, it was estimated that up to 60% of children in care of the child welfare system had a developmental disability compared to around 10% in the general population.<sup>115</sup> In Manitoba, 17% of children in care have or are suspected of having FASD<sup>116</sup> and children with FASD come into care at an earlier age, become permanent wards more quickly, and spend a greater proportion of their lives in care than children with other disabilities and children with no disability.<sup>117</sup>

#### 4.3.1.4 Safe neighbourhoods

Neighbourhood safety is an important factor in raising a child. Research has found that parents' fear of danger and perception of social disorder in the neighbourhood can affect their sense of attachment to the neighbourhood and their parenting strategies.<sup>118</sup> Safer and more cohesive

neighbourhoods, and a lack of neighbourhood problems are associated with positive developmental outcomes and better child health.<sup>119</sup>

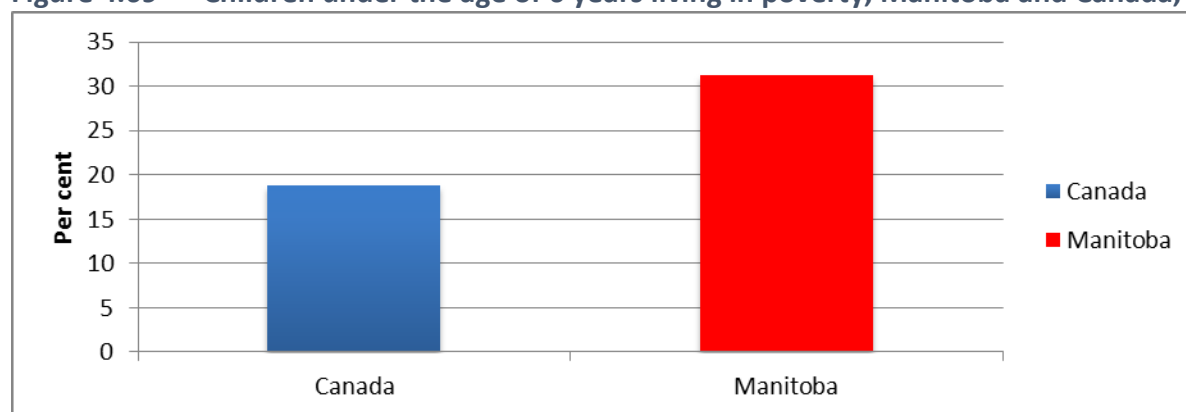
### 4.3.2 Security

Security of income, food, and housing are important factors in providing a stable, predictable environment in early childhood. Also important to a developing child is emotional security – a positive environment with supportive relationships.

#### 4.3.2.1 Income security

The health, well-being and development of young children is particularly vulnerable to the effects of living in poverty. Therefore, it is of great concern that more than one-third (31.2%) of Manitoban children under 6 years of age lived in poverty (as defined by the Low Income Measure) in 2015. This is 1.7 times the rate of poverty for young children in all of Canada, and only second in the country to the rate in Nunavut (Figure 4.69).

**Figure 4.69 Children under the age of 6 years living in poverty, Manitoba and Canada, 2015**



Source: Campaign 2000 and Winnipeg Harvest Inc. Manitoba Child and Family Report Card 2017. Waiting for the Plan. [https://campaign2000.ca/wp-content/uploads/2017/11/2017-MB\\_ChildFamilyPovReportCard\\_FINAL.pdf](https://campaign2000.ca/wp-content/uploads/2017/11/2017-MB_ChildFamilyPovReportCard_FINAL.pdf) (Accessed December 14, 2017)  
Note: Poverty is defined by the Low Income Measure.

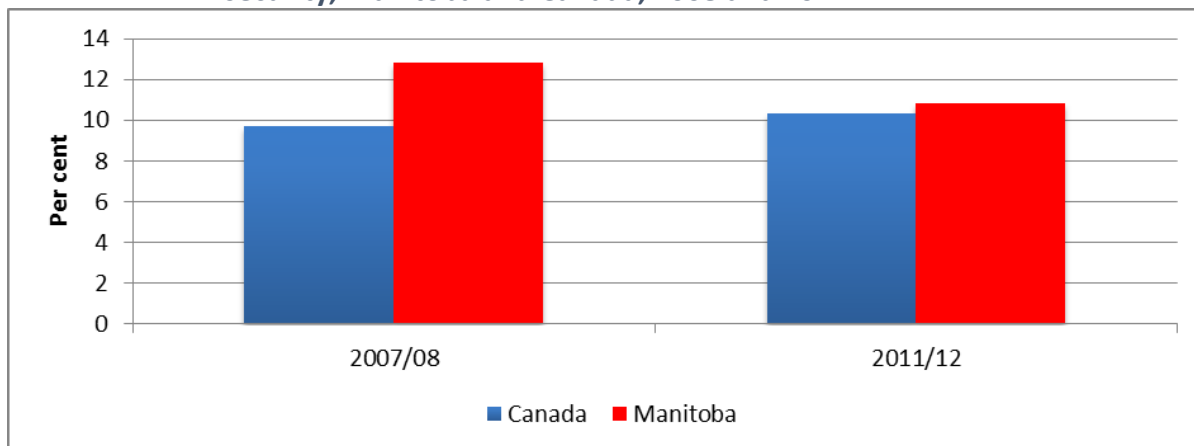
#### 4.3.2.2 Food security

Food insecurity is closely intertwined with poverty. Children grow rapidly in the early years, and having enough food, as well as quality nutrients, is vital to their development. Children who are hungry are more likely to be hyperactive, more likely to miss school, and are at a higher risk of poor psychological health. Food insecurity may also result in poor physical growth and nutritional deficiencies such as anemia.<sup>78</sup>

In 2011/12, 12% of Manitoba households with children under 6 years of age reported food insecurity (Figure 4.70). This was higher than the prevalence of food insecurity among families with older children (6 to 17 years), 9.7%, and was 1.7 times the prevalence of households without children.<sup>120</sup> The prevalence of food insecurity in households with children under 6 years of age in Manitoba was higher than for Canada overall, although Manitoba food insecurity declined between 2007/08 and 2011/12.



**Figure 4.70 Per cent of households with children under 6 years experiencing food insecurity, Manitoba and Canada, 2008 and 2012**



Source: Statistics Canada. Table 105-0546 - Household food insecurity measures, by presence of children in the household, Canada, provinces and territories. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1050546&p2=33> (Accessed September 11, 2017)

## 4.4 Successful at Learning

### 4.4.1 Early Learning and Child Care (ELCC)

The majority of parents in Manitoba work outside of the home, and this means parents require non-parental child care. There is considerable evidence that ELCC programs are a central factor in healthy child development, and the benefits are long term. High quality ELCC provides intellectual and social stimulation that promotes cognitive development and social skills. This is especially true for low-income children: high quality child care has been linked with lower juvenile crime and school dropout rates, and much higher earnings as adults. Child care also facilitates parental employment and training, particularly for women, and thus is linked to family income, which has demonstrated effects on the health and well-being of children.<sup>121</sup>

Manitoba has an online childcare registry that helps families find and apply for a child care space in licensed Manitoba facilities. As of April 30, 2017 there were almost 16,878 active child care registrants in Manitoba, and the majority of the spaces were in Winnipeg. There were almost 6,000 children from 0 to 2 years of age who were active child care registrants and 1,144 who were not yet born. (Table 4.1) Active registrants represent children (born and not born) who are waiting for child care in a licensed facility.

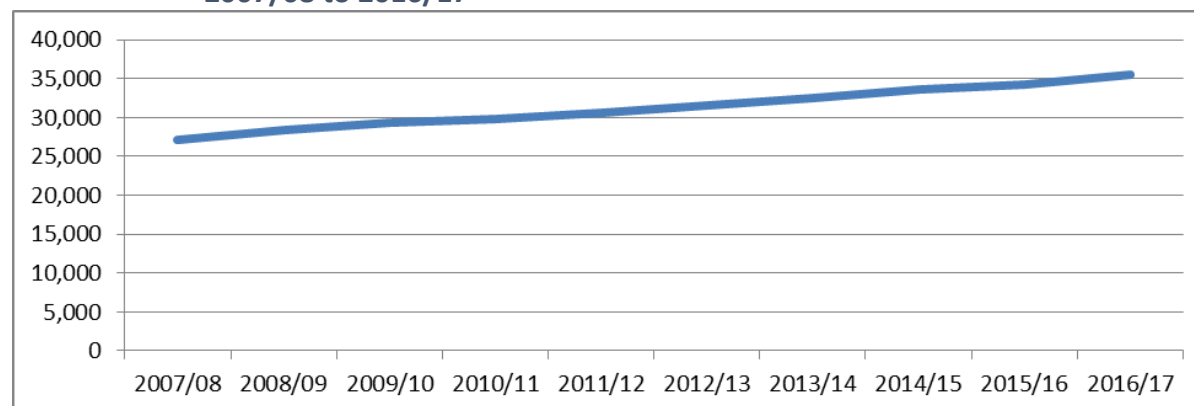
**Table 4.1 All active child care registrants, Manitoba, April 30, 2017**

Region	Children less than 1 year	Children 1 to 2 years	Children 2 or more years	Total children born	Children not yet born	Total (all children)
Westman	261	163	417	841	59	900
Parkland	59	43	153	255	37	292
Northern	85	83	193	361	12	373
Interlake	160	128	427	715	52	767
Central	166	124	584	874	63	937
Eastman	222	162	649	1,033	82	1,115
Winnipeg	2,457	2,308	8,426	13,191	908	14,099
Less registrants in multiple areas	(224)	(217)	(1095)	(1536)	(69)	(1605)
<b>Total unique children province-wide</b>	<b>3,186</b>	<b>2,794</b>	<b>9,754</b>	<b>15,734</b>	<b>1,144</b>	<b>16,878</b>

Source: Online Child Care Registry Manitoba Government, Department of Families, Early Learning and Child Care Program. [http://www.gov.mb.ca/fs/childcare/occr/pubs/stats\\_apr\\_2017.pdf](http://www.gov.mb.ca/fs/childcare/occr/pubs/stats_apr_2017.pdf) (Accessed September 18, 2017)

As of March 31, 2016, there were 34,285 licensed child care spaces for children under 12 in Manitoba; a year later, by March 31, 2017, the number of licensed child care spaces had increased by 1,184 to 35,469 (Figure 4.71).

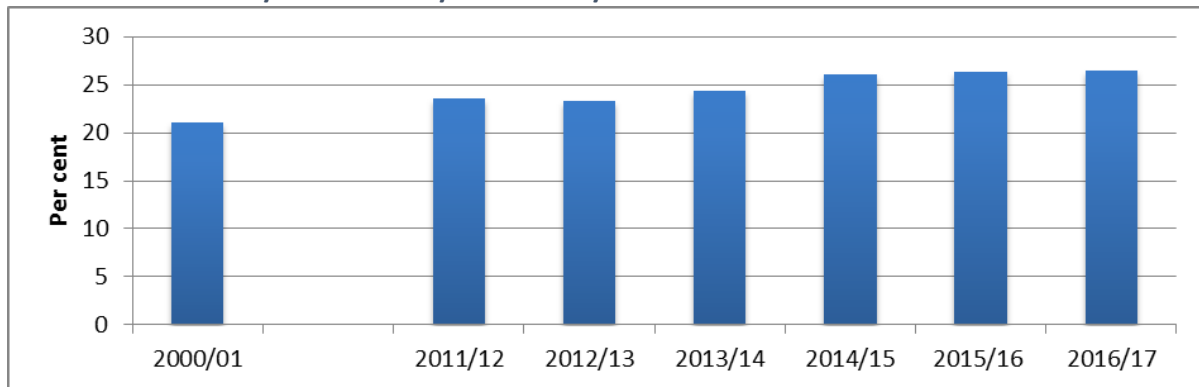
**Figure 4.71 Number of licensed child care spaces for children under 12 years, Manitoba, 2007/08 to 2016/17**



Source: Government of Manitoba, Department of Families Annual Report, 2007/08, 2008/09, 2009/10, 2010/11, 2011/12, 2012/13, 2013/14, 2014/15, 2015/16, 2016/17 [https://www.gov.mb.ca/fs/about/annual\\_reports.html](https://www.gov.mb.ca/fs/about/annual_reports.html) (Accessed July 24, 2017)

The percentage of Manitoba children under 6 years for whom there was a regulated child care space increased from 21.0% in 2000/01 to 26.5% in 2016/17 (Figure 4.72).

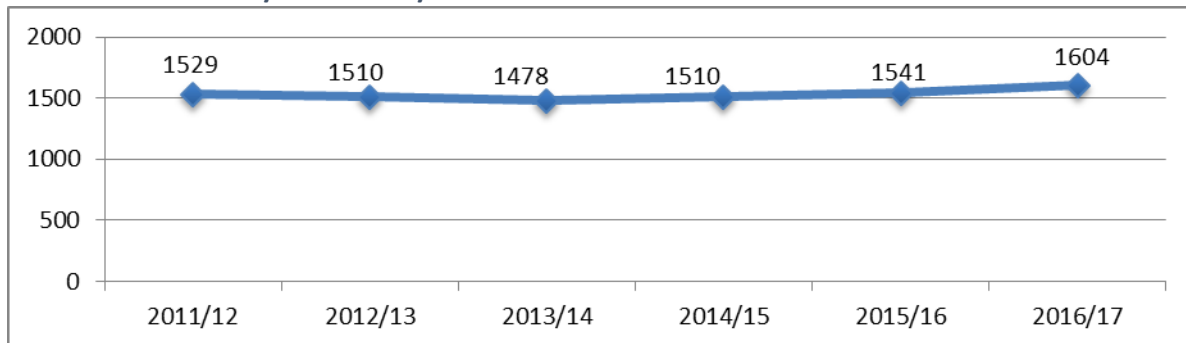
**Figure 4.72 Per cent of children under 6 years with a regulated child care space, Manitoba, 2000/01 and 2011/12 to 2016/17**



Source: Manitoba Government, Child and Family Services Annual Report, 2011/12, 2012/13, 2013/14, 2014/15, 2015/16. [https://www.gov.mb.ca/fs/about/annual\\_reports.html](https://www.gov.mb.ca/fs/about/annual_reports.html) Accessed September 20, 2017

The Inclusion Support Program (ISP) helps child care centres, nursery schools, and family and group child care homes to reduce or eliminate barriers, allowing a child with a disability and/or emotional/behaviour needs to meaningfully participate in programming. ISP funding support is not an entitlement; however, legislation requires all licensed facilities to have a written inclusion policy and provide a daily program that is inclusive of all children, including children with additional support needs. As such, there is an expectation that families with children who have a disability and/or emotional behaviour needs will have equal access to licensed child care and that child care programs will make adaptations for all children to meaningfully participate (Figure 4.73).

**Figure 4.73 Number of children served under the Inclusion Support Program, Manitoba, 2011/12 to 2016/17**



Source: Manitoba Family Annual Report: 2011-2012, 2012-2013, 2013-2014, 2014-2015, 2015-2016, 2016/17. [http://www.gov.mb.ca/fs/about/pubs/fsar\\_2015-16.pdf](http://www.gov.mb.ca/fs/about/pubs/fsar_2015-16.pdf) (Accessed September 19, 2017)

According to a recent Canadian study examining child care fees in 28 Canadian cities, the median monthly fees in Winnipeg were quite low in comparison to other Canadian cities outside of Québec. Median monthly fees in Winnipeg for infant care were \$651 and for toddler care were \$45; this is the 6th lowest of the 28 Canadian cities included in the study. There were no changes in toddler fees from 2014 to 2016 in Winnipeg. This is unlike numerous other cities where fees have increased. Manitoba has fees set by the province with base funding paid to service providers.<sup>122</sup>

#### 4.4.2 Language and Vocabulary

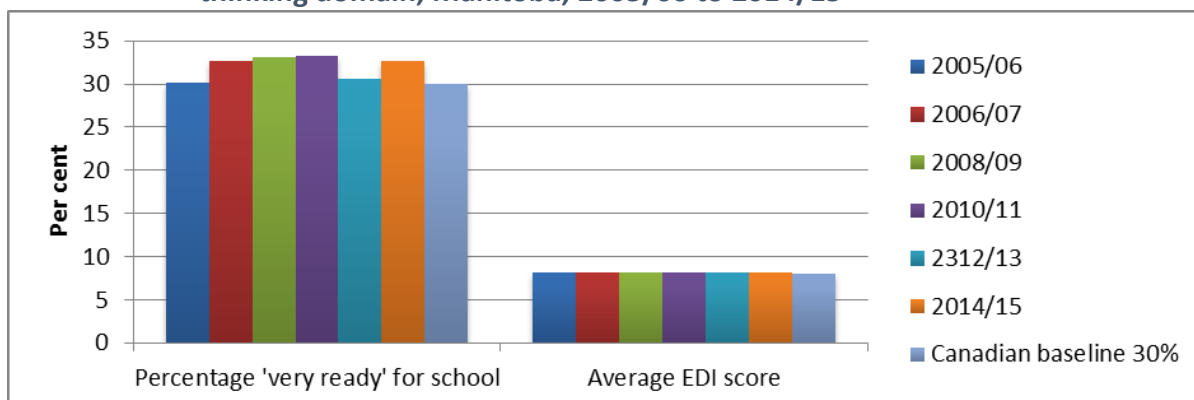
Socioeconomic status, amount of language exposure, and health are important factors in predicting a child’s language development and ultimately their academic success. Post-birth exposure to language is a predictor of early vocabulary and later verbal and literacy skills.<sup>123,124</sup> Exposure tends to correlate with socioeconomic status: on average, children raised in higher socioeconomic status families are exposed to more words and have larger vocabularies than children in lower socioeconomic status families.<sup>125</sup> Children with low verbal skills at age 3 will tend to have poorer literacy skills entering school and are more likely to have lower academic performance.<sup>126</sup>

Research shows that individual differences in language and vocabulary as children enter school can worsen as children develop. Evidence suggests that early interventions can help to minimize these difficulties as they develop, by opening learning opportunities that might otherwise have been inaccessible at that time in the child’s development.<sup>127</sup> The EDI measures the language and thinking skills of young children which is defined by basic literacy, interest and memory, complex literacy and basic numeracy.

Between 2005/06 and 2014/15, Manitoba’s average EDI scores on language and thinking were stable at 8.2 to 8.8, and Manitoba’s baseline average score was similar to the Canadian baseline average. The percentage of Manitoba children who were assessed as “very ready for school” for language and thinking improved from 30% to 33% from 2005/06 to 2014/15 and was above the Canadian baseline average (Figure 4.74).

Girls had higher average scores on the language and thinking domain than did boys. Children older than 5.6 years scored higher on average than those who were younger than 5.6 years. Children with English as an additional language, or French as an additional language, had lower average scores than children without the additional languages. There was no difference in the average scores between Indigenous children and non-Indigenous children. Children who had recently immigrated had lower average scores than children who had not.<sup>94</sup>

**Figure 4.74** Per cent of children who are very ready for school according to the language and thinking domain of the EDI and average EDI score on the language and thinking domain, Manitoba, 2005/06 to 2014/15



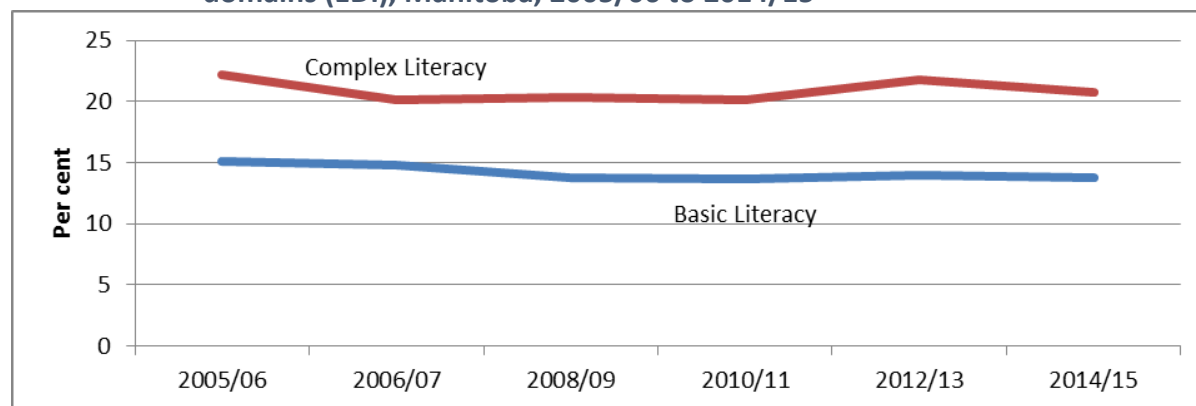
Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report.  
 Notes: The Canadian EDI baseline is from a national representative subgroup of the EDI collected over the years 2004/05, 2005/06 and 2006/07. This represents about 53% of all Kindergarten children in Canada. The Canadian baseline is used to compare to Manitoba scores over

three years of data collection. 2005/06 was the first year that all 37 school divisions in Manitoba participated and was collected biennially after 2006/07.

Anything above 30% (i.e. higher than the Canadian baseline sample) is a domain of strength.

The EDI measures children’s literacy skills in two sub-domains. *Basic literacy* refers to identifying letters or attaching sounds to letters, rhyming, writing direction and knowing how to write their name. *Complex literacy* refers to reading or writing simple words or sentences and writing voluntarily. In 2014/15, 14% of Manitoba children were vulnerable in the basic literacy skills, down from 15% in 2005/06. In 2014/15, 21% of Manitoba children were vulnerable in complex literacy skills, down from 22% in 2005/06 (Figure 4.75).

**Figure 4.75 Per cent of children vulnerable in the basic literacy and complex literacy sub-domains (EDI), Manitoba, 2005/06 to 2014/15**



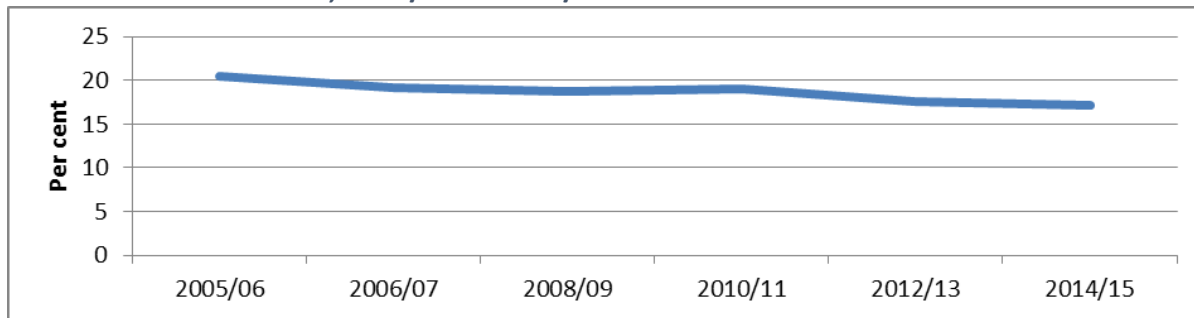
Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report.  
Notes: The Canadian EDI baseline is from a national representative subgroup of the EDI collected over the years 2004/05, 2005/06 and 2006/07. This represents about 53% of all Kindergarten children in Canada. The Canadian baseline is used to compare to Manitoba scores over three years of data collection. 2005/06 was the first year that all 37 school divisions in Manitoba participated and was collected biennially after 2006/07. This shows the proportion of children who have met few/none developmental expectations (or, who are considered vulnerable) across the sub-domains.

### 4.4.3 Numeracy

As with reading and language development, early experiences with numbers can increase children’s aptitude and readiness for school. Children who are exposed to numeracy-related experiences at home tend to be more skilled at school-based mathematical activities.<sup>128</sup> A meta-analysis of the long-term impacts of several early learning programs found that math skills at the point of school entry are consistently associated with higher levels of academic performance in later grades.<sup>129</sup>

The EDI also measures basic numeracy skills. Basic numeracy refers to counting, comparing or recognizing numbers, naming shapes and time concepts. In 2014/15, 17% of Manitoba were vulnerable in the basic literacy skills, down from 21% in 2005/06 (Figure 4.76).

**Figure 4.76 Per cent of children vulnerable in the basic numeracy sub-domain (EDI), Manitoba, 2005/06 to 2014/15**



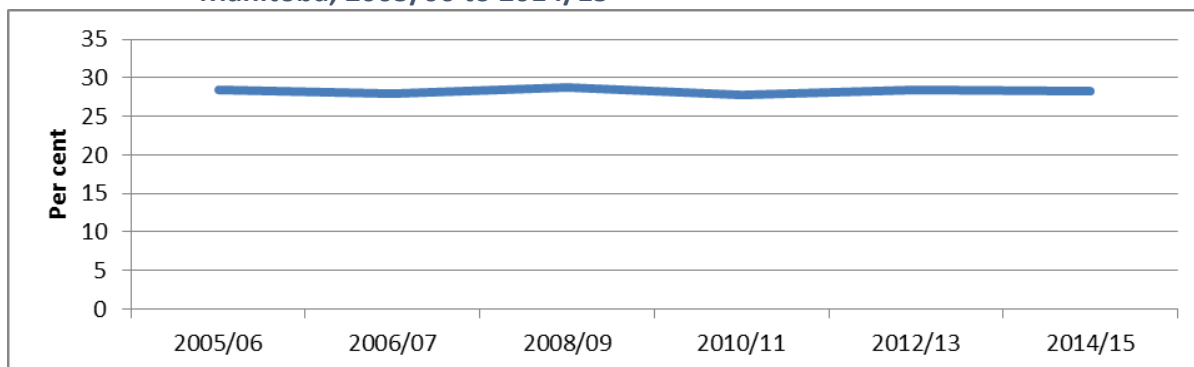
Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report. [https://www.gov.mb.ca/healthychild/edi/edi\\_1415/2014\\_15\\_edi\\_provincial\\_report.pdf](https://www.gov.mb.ca/healthychild/edi/edi_1415/2014_15_edi_provincial_report.pdf) (Accessed September 19, 2017)

#### 4.4.4 School Readiness

When children enter Kindergarten, they start a new and important phase of their lives that exposes them to new stimuli which fosters their social, emotional, academic, and physical development. How ready children are for school is an important indicator of how well they will be able to benefit from what school can offer.<sup>130</sup> A Manitoba study found a strong association between children’s school readiness (as measured by the EDI) and their outcomes for Grade 3 assessments of reading and numeracy, indicating that school trajectories begin setting in when children are very young, before starting school.<sup>131</sup>

According to the EDI, in 2014/15, 28% of Manitoba children were assessed as being “not ready for school” in one or more domains on the EDI, compared to 26% for Canada overall.<sup>132</sup> The rate in Manitoba has been relatively stable since 2005/06 (Figure 4.77).

**Figure 4.77 Per cent of children who are not ready for school in one or more domains (EDI), Manitoba, 2005/06 to 2014/15**



Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report. [https://www.gov.mb.ca/healthychild/edi/edi\\_1415/2014\\_15\\_edi\\_provincial\\_report.pdf](https://www.gov.mb.ca/healthychild/edi/edi_1415/2014_15_edi_provincial_report.pdf) (Accessed September 19, 2017)

#### 4.4.5 Indigenous Culture

While culture is transmitted primarily through families, many Indigenous nations, organizations, communities and individuals are actively undertaking systems work to revive and reconnect to First Nation, Métis and Inuit languages and culture.

Within the public school system, Indigenous languages, cultures, and histories are taught primarily through the Social Studies curricula.

- Indigenous Peoples are an integral part of the development process of the land we now call Canada. Indigenous culture and history are deeply and authentically embedded throughout the curricula.
- Indigenous-related learning outcomes have been included for all students at each grade and are intended to help students develop knowledge and understanding of Indigenous culture and history. In addition, Indigenous student-specific learning outcomes are included in order to enhance the development of language, identity, culture and community for Indigenous learners.
- Treaty Education and Residential Schools education are part of the mandatory Social Studies curricula, with Residential Schools a focus at Grades 9 and 11 and Treaty Education a focus at Grades 5 and 6 in particular.
- The November 2017 speech from the Throne included a committee to work with the Treaty Relations Commission of Manitoba and the Assembly of Manitoban Chiefs on treaty education.

Other curricula, including science, English language arts and Kindergarten, include Indigenous perspectives and opportunities to study Indigenous cultures, history and ways of knowing as an “integratable” area that is on a priority level similar to Education for Sustainable Development and Information and Communications Technology

## **4.5 Socially Engaged and Responsible**

### **4.5.1 Socially Engaged**

In early childhood, the most important social environment is the family. However, even infants and toddlers are socially engaged in their preschools and other early childhood education settings, neighbourhoods and communities, and extended families. The quality of these social environments in the early years is an important predictor of future health.<sup>127</sup> Unfortunately, we do not have recent data regarding social engagement of young children.

### **4.5.2 Socially Responsible**

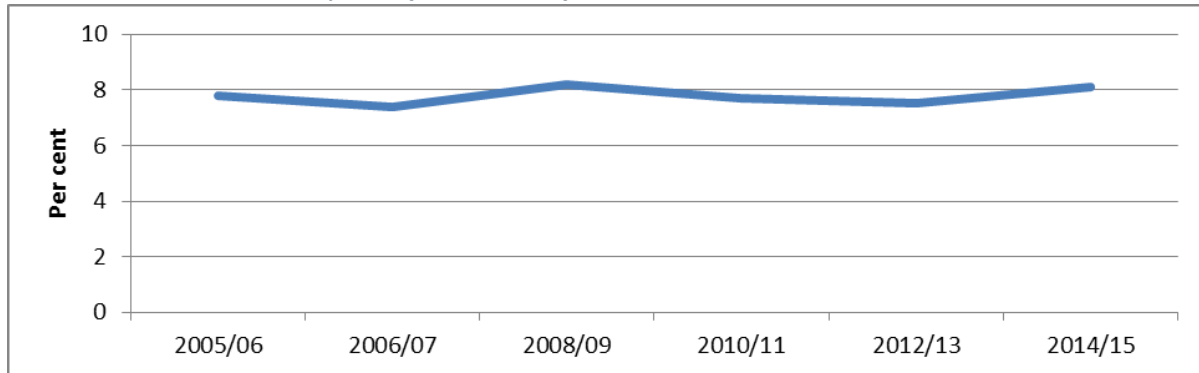
Relationships with other children begin to develop remarkably early: Interest in other babies can begin as early as 2 months.<sup>133</sup> As they get older, children begin to interact with other children in preschools and other early childhood settings, in community centres, playgrounds. As children develop mentally and emotionally, they learn behaviours that help them navigate through their increasingly social world. Key skills developed in this social environment include how to play, how to form and maintain friendships, and how to handle conflict.<sup>127</sup> While they tend to view the world from their own point of view, many preschoolers are developing empathy skills and the ability to control their own emotional expressions.<sup>134</sup>

#### *4.5.2.1 Aggression*

Physically aggressive behaviour in situations of social conflict is most prevalent by age 2, after which most children learn to control their behaviour and verbally negotiate instead. Measuring physical aggression is important: studies have shown that children who are not able to control their physical aggression by school age are at higher risk of failing a grade and engaging in antisocial behaviour by adolescence.<sup>135,136</sup>

The EDI measures aggressive behaviour, defined as often showing most of the following indicators: getting into physical fights, kicking or biting others, taking other people’s things, being disobedient or having temper tantrums. In 2014/15, 8% of Manitoba children were vulnerable on the aggression sub-domain (Figure 4.78).

**Figure 4.78 Per cent of children vulnerable in the aggression sub-domain (EDI), Manitoba, 2005/06 to 2014/15**



Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report. [https://www.gov.mb.ca/healthychild/edi/edi\\_1415/2014\\_15\\_edi\\_provincial\\_report.pdf](https://www.gov.mb.ca/healthychild/edi/edi_1415/2014_15_edi_provincial_report.pdf) (Accessed September 19, 2017)

#### 4.5.2.2 Social competence

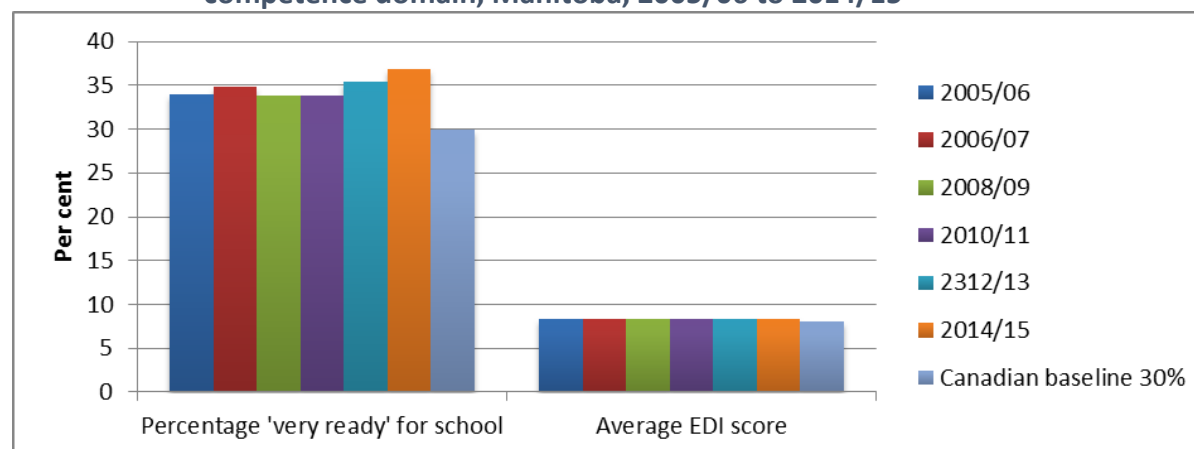
Social competence reflects a young child’s ability to successfully navigate the social world. Aspects of social competence can include social skills such as cooperation with others, respect for others and their belongings, taking responsibility for one’s actions, problem solving, and independent exploring. Positive social interactions are a key component of readiness for school.

In Manitoba, average EDI scores for the social competence domain ranged from 8.3 to 8.4 between 2005/06 and 2014/15, (10 is the best possible score). The percentage of children assessed to be “very ready” in the social competence domain was 34% in 2005/06 and 37% in 2014/15 (Figure 4.79).

Girls had higher average scores in the social competence domain compared to boys. Children older than 5.6 years scored higher on average than those who were younger than 5.6 years. Children with English as an additional language, or French as an additional language, had lower average scores than children without the additional languages. There was no difference in the average scores of children who had recently immigrated compared to those who had not. Indigenous children had lower average scores than non-Indigenous children.<sup>94</sup>



**Figure 4.79** Per cent of children who are very ready for school according to the social competence domain of the EDI and average EDI score on the social competence domain, Manitoba, 2005/06 to 2014/15



Source: Healthy Child Manitoba Office. The Early Development Instrument (EDI) Report: 2014-2015. Manitoba Provincial Report. [https://www.gov.mb.ca/healthychild/edi/edi\\_1415/2014\\_15\\_edi\\_provincial\\_report.pdf](https://www.gov.mb.ca/healthychild/edi/edi_1415/2014_15_edi_provincial_report.pdf) (Accessed September 19, 2017)

## 4.6 Summary

The first five years of life are a significant and sensitive period that can profoundly affect the future of a child. In early childhood, brain development is very responsive to all experiences, both positive and negative. Healthy social, emotional, and physical environments in the home and broader community are important for healthy child development.

- Manitoba's preterm birth and low birth weight rates are relatively stable and similar to Canada.
- Manitoba has a larger proportion of babies born large-for-gestational age than Canada, but the rate appears to be declining faster over time in Manitoba.
- Breastfeeding initiation and exclusive breastfeeding have increased over time in Manitoba and are now both higher than in Canada.
  - Breastfeeding initiation increased from 84% in 2007-2008 to 93% in 2011-2012
  - Exclusive breastfeeding for at least six months increased from 25% in 2007-2008 to 31% in 2011-2012. The Canadian rate was 26% in 2011-2012.
- Pediatric dental extractions and surgeries (under age 6 years) have both declined over the last decade.
  - The rate of dental extractions among children under 6 was 18 per 1,000 in 2006/07, and 11 per 1,000 in 2015/16
- Immunization rates among children at age 2 are relatively stable, but still lower in children in families living in lower-income, First Nations families, or families led by teen-aged mothers.
- Over the past decade, the early physical health and well-being, and emotional maturity, of Manitoba's Kindergarten children has been stable, at levels similar to Canada.
- Infant (under age 1) injury hospitalization rates appear to be increasing, while preschool (age 1-4) rates appear to be decreasing, with falls as the number one cause.
- Infant mortality continues to be higher in Manitoba than in the rest of Canada, particularly in northern Manitoba.

- Between 2010/11 and 2014/15, Manitoba’s overall crude infant mortality rate was 5.9 per 1,000 live births. This varied by region – the highest rate being in the Northern Region (10.9) and the Southern Region had the lowest rate (4.8).
- One in three Manitoba children under age 6 lives in poverty (1.7 times higher than Canada rate), and one in eight lives with food insecurity, also higher than Canada.
- In 2016/17, 1,371 children and youth under 18 accessed an emergency family violence shelter funded by the Manitoba Government. That number fluctuated slightly over the five preceding years.
- More children under age 6 have access to licensed early learning and child care. Approximately three in four preschoolers do not.
- Over the past decade, the early language and cognitive development (early literacy and numeracy) of Manitoba’s Kindergarten children has been stable at a provincial level, but with significant variation across communities.
- Children’s overall readiness to start school in Kindergarten has remained stable over time, with more than one in four children not ready in at least one area of early development (e.g., physical, social, emotional, cognitive and general knowledge).

## Chapter 5. Middle Childhood (Ages 6 to 14 Years/Grades 1 to 8)

Middle childhood is often overlooked, yet it is a period in which significant developmental milestones are achieved. For children ages 6 to 14, developmental tasks and stages include increasing physical, emotional, learning, and social abilities and capacities. Physically, children continue to develop rapidly, growing 5 to 8 cm and adding about 2.75 kg in weight each year. Along with growing bones and muscles, children's brains are also developing in middle childhood, leading to improved motor skills and muscle coordination, as well as increases in cognitive speed, memory and language development. With these changes comes the ability to engage with and explore the world in new and more sophisticated ways.<sup>58</sup>

Toward the end of the middle years, from around 11 to 14, the physical changes associated with puberty begin. Hormonal changes and the development of functioning reproductive systems occur. Because puberty begins at different times for different people, and progresses at varying rates, it is common for youth to be at a different stage of physical development from their peers, which can make some self-conscious.

Identity formation and healthy self-concept are important aspects of emotional development in middle childhood. Children begin to develop a more complex "image of self": a set of perceptions and feelings about who they are, what they like, and what they are able to do. The self-concept is now defined in relation to others: children evaluate themselves against their peers, and these judgments become key components of self-esteem. Self-esteem is also shaped by the overall support, love, and acceptance children feel they are receiving from parents, peers, and others. Like attachment, self-esteem is crucial to social and emotional development, but it is not cast in stone. Later influences can improve or damage self-esteem.<sup>58</sup>

In middle childhood, children enter school, make new friends, and begin to engage more with the world outside of the home. One of the hallmarks of middle childhood is the first day of school in Grade 1. Moving from the safe familiarity of home and family to a school with new people and new activities is, for many, an exciting experience.

From the first day of school, two worlds begin to develop: one in the home and the other at school. While family remains an important "home base", school-age children become increasingly social with children their own age, and peers and close friends begin to play a more important role. Often during middle childhood, a "best friend" develops who is more than just a playmate but is also a person of trust and confidence.<sup>137</sup> Children learn to not only build relationships, but also manage conflict. These developing social skills form an important foundation for adolescent and adult relationships.

With increased time outside of the home, there is also increasing autonomy and testing of limits. However, independence and risk taking can lead to increased vulnerability. While risks inside the home continue to be important, risks are increasingly found outside of the home: in neighbourhoods and schools, in the cyber world, and in peer groups. As the importance of peers increases, so does the vulnerability to peer pressure and bullying.

School is also the beginning of a structured environment in which children are evaluated in the context of their peers. Entry into school marks a new period of learning that is oriented to

academics.<sup>138</sup> Teachers and staff become increasingly important in a child’s life and can help build self-esteem. Thus, school becomes a major part of children’s lives, and school experiences have a great impact not only academically, but also socially and emotionally.<sup>139,140,141</sup>

## 5.1 Physically Healthy

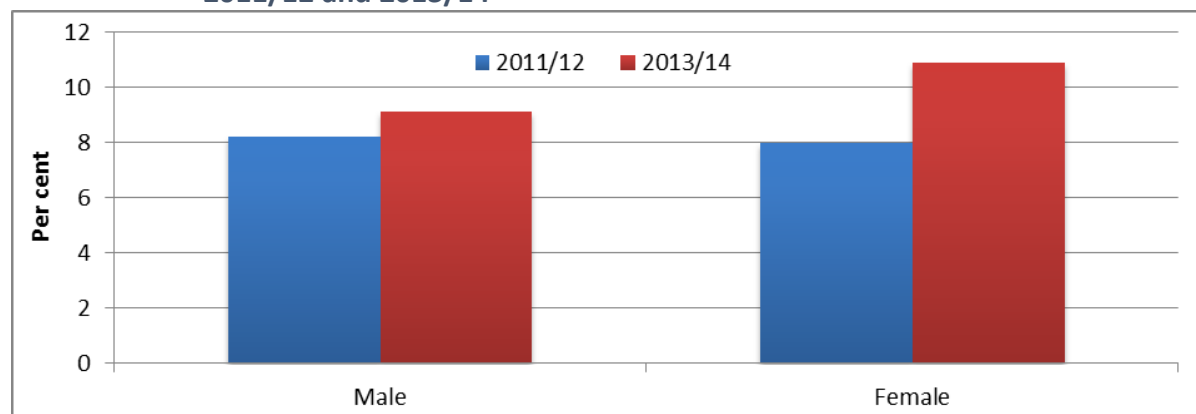
As children continue to grow and develop through middle childhood, a number of potential physical risks and opportunities are present. These include challenges and resiliencies associated with chronic illness and disability, as well as opportunities to develop behaviours and routines that can contribute to good physical health, including oral hygiene, physical activity, and nutrition.

### 5.1.1 Chronic Illness Development

Two common chronic diseases begin to appear in middle childhood. Asthma is the most common chronic condition in children. Generally, asthma rates decline with age, with some children “growing out of” asthma in the teen years.<sup>70</sup>

The self-reported rate of asthma for 12- to 14-year-olds in Manitoba was 9% for boys and 11% for girls in 2013/14, compared with 8% for both boys and girls in 2011/12 (Figure 5.80). The rate for Canada was 13% for boys and 9% for girls.<sup>25</sup>

**Figure 5.80 Per cent of youth ages 12 to 14 with asthma, by sex, Manitoba, 2011/12 and 2013/14**



Source: Canadian Community Health Survey 2001-20012 and 2013-2014, Public Use Data Set, Accessed through ODESI.

The Canadian Community Health Survey does not include families living in First Nations Communities.

Note: Having asthma is defined as being diagnosed by a health professional and the asthma is expected to last or has already lasted 6 months or more.

According to the Aboriginal Peoples Survey, in 2012 26% of First Nations children aged 6 to 11 had asthma, as did 19% of Métis children in the same age group.<sup>142</sup>

According to a recent report from the Manitoba Centre for Health Policy, asthma was more prevalent among children who have developmental disorders, and certain mental health disorders, such as mood and anxiety disorders, psychotic disorders and externalizing disorders, were more likely to have asthma than children without these disorders.<sup>143</sup>

## 5.1.2 Disability

Internationally, about 4 to 6.5% of children and youth have disabilities.<sup>144</sup> In Canada, there are approximately 850,000 children with developmental disabilities.<sup>145</sup> Children with developmental disabilities may experience lifelong challenges with mobility, language, learning, socialization, and/or self-care. The early signs and symptoms of childhood disability can vary greatly, but there are tools available to help children with disabilities overcome life's challenges. Children's needs are individual, but early diagnosis and care can have a positive impact and improve outcomes for all children.<sup>145</sup>

The transition from home to school is a key time for identifying some disabilities in children. For example, learning disabilities are not always apparent until children begin school.

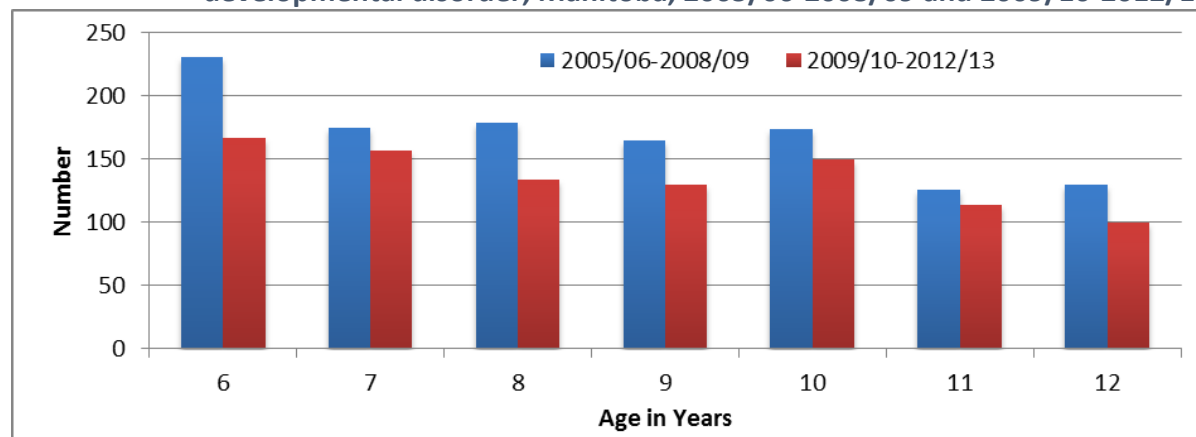
### 5.1.2.1 Developmental disorders

Developmental disorders “are characterized by significant impediments in intellectual and adaptive functioning from a very early age. ‘Adaptive functioning’ means carrying out everyday activities, such as communicating and interacting with others, managing money, doing household activities, and attending to personal care.”<sup>143</sup> Disorders include intellectual disability, chromosomal anomalies (including Down's, Patau's and Edward's syndromes), FASD, and Autism Spectrum Disorder (ASD).

In the years 2009/10 to 2012/13, the lifetime diagnostic prevalence of developmental disorders was 3.2% among Manitoba children aged 6 to 12. This has been stable since 2005/06 to 2008/09, when it was 3.0%. Compared to the Manitoba prevalence, the prevalence was lower in Southern Health/Santé Sud in both time periods. The prevalence in Winnipeg RHA increased from the first to the second time period and was higher than the Manitoba rate in both years.<sup>143</sup>

In the years 2009/10 to 2012/13, 952 children ages 6 to 12 years were diagnosed with a developmental disorder for the first time. That was down from 1,180 in the years 2005/06 to 2008/09. Diagnosis is more likely to happen in younger children than in older children (Figure 5.81).

**Figure 5.81** Number of children aged 6 to 12 diagnosed for the first time with a developmental disorder, Manitoba, 2005/06-2008/09 and 2009/10-2012/13



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, Burchill C, Hu M, Rajotte L, Kulbaba C. The Mental Health of Manitoba's Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. [http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf) (Accessed August 19th 2017)

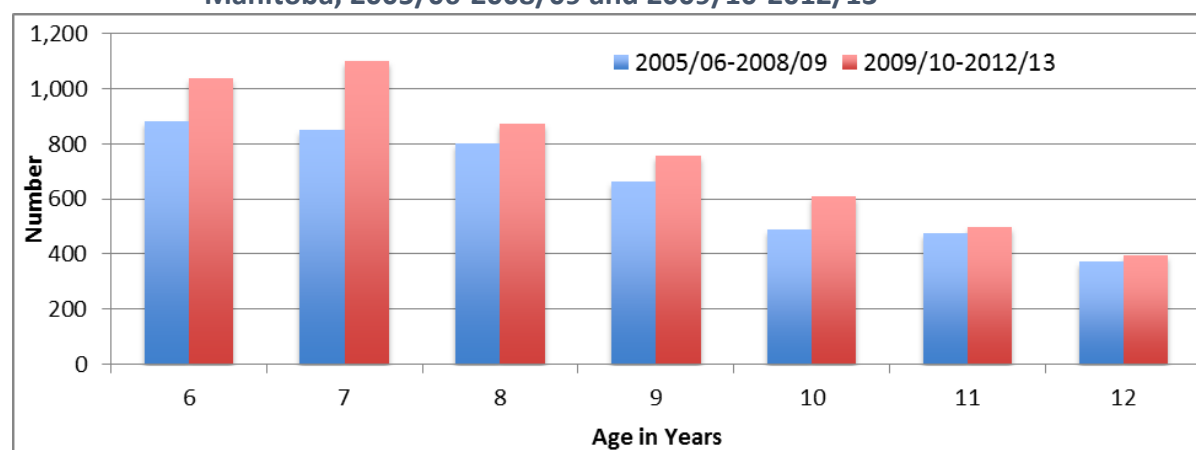
### 5.1.2.2 Attention Deficit Hyperactivity Disorder (ADHD)/hyperactive behaviour

Hyperactivity is the most common behavioural disorder identified in school-aged children.<sup>70</sup> Children who are overly restless and unable to concentrate are less likely to succeed academically, and more likely to experience family conflict and poor peer relationships.<sup>131</sup>

For reporting purposes, a child is considered to have a diagnosis of ADHD if he/she meets at least one of a number of specific criteria including physician visits, hospitalization, and/or prescription of medications for ADHD. According to this definition, from 2005/06 to 2008/09, the prevalence of ADHD among children ages 6 to 12 years was 7.5%. That rate increased to 8.7% in the 2009/10 to 2012/13 period.

In the years 2009/10 to 2012/13, 5,276 children ages 6 to 12 were diagnosed with ADHD. That was up from 4,535 in the years 2006/06 to 2008/09. Diagnosis happens more frequently among younger children than older children in this age group (Figure 5.82).

**Figure 5.82** Number of children aged 6 to 12 diagnosed for the first time with ADHD, Manitoba, 2005/06-2008/09 and 2009/10-2012/13



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, Burchill C, Hu M, Rajotte L, Kulbaba C. The Mental Health of Manitoba's Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. [http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf) (Accessed August 19th 2017)

According to the Aboriginal Peoples Survey (APS), in 2012, 10% of Manitoba Indigenous (First Nations, Métis and Inuit) children ages 6-11 years had attention deficit disorder<sup>d</sup> while 10% of Métis children had attention deficit disorder (the rate is not available for First Nations children due to sample size).<sup>142</sup> In the APS, attention deficit disorder (with or without hyperactivity) is defined as a chronic neurobiological disorder that includes an inability to sustain attention and concentration, distractibility and impulsivity.

<sup>d</sup> The Aboriginal Peoples Survey defines Attention deficit disorder (with or without hyperactivity) as a chronic neurobiological disorder that includes an inability to sustain attention and concentration, distractibility and impulsivity.

### 5.1.2.3 Autism Spectrum Disorder (ASD)

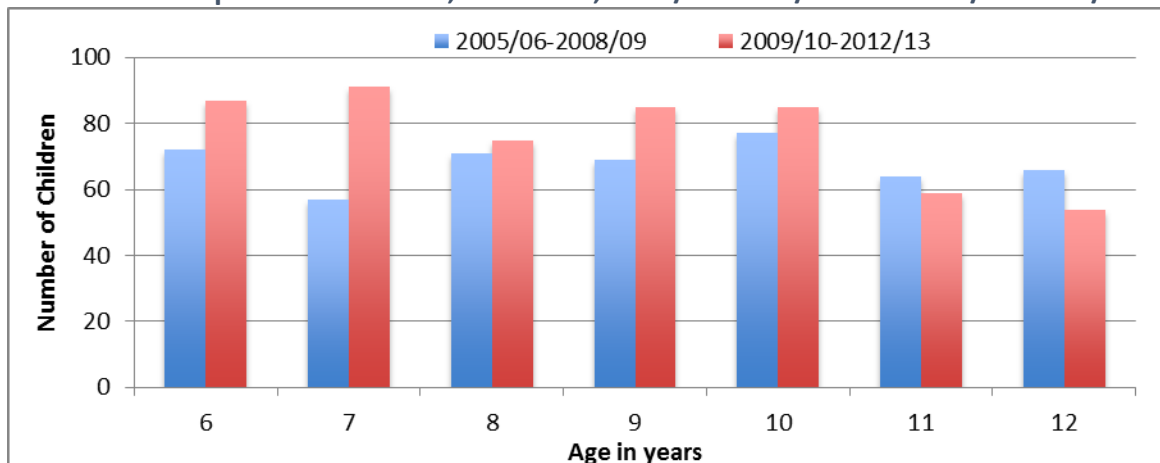
Autism spectrum disorder is a developmental disorder that includes difficulties with social communication and interaction, as well as restricted and repetitive patterns of behaviour, interests, or activities.<sup>146</sup> It is a lifelong disorder.

ASD<sup>e</sup> is considered the fastest growing and most commonly diagnosed neurological disorder in Canada. The causes are complex and include genetic and environmental influences. It affects all racial, ethnic and socioeconomic groups. Early identification, care and intervention is very important, and can make a difference not only to children and youth, but through adulthood.<sup>147</sup>

According to a recent report from the Manitoba Centre for Health Policy, the lifetime diagnostic prevalence of ASD among Manitoba children ages 6 to 12 was 1.5% in the 2009/10 to 2012/13 period, up from 1.2% in 2005/06 to 2008/09. The prevalence was higher in the Winnipeg Regional Health Authority during both periods, and lower in Southern Health/Santé Sud and Northern Health Region during both periods. The prevalence increased in Winnipeg RHA, Interlake-Eastern RHA and Manitoba overall.<sup>143</sup>

In 2005/06 to 2008/09, there were 476 Manitoba children diagnosed with autism, rising to 536 in 2009/10 to 2012/13. Most children are diagnosed before age 6, but between 54 and 91 children were diagnosed at each age in the 6 to 12 age group in 2009/10 to 2012/13. The number of children diagnosed increased for each age, except for 11- and 12-year-olds, indicating that children are being diagnosed earlier (Figure 5.83).

**Figure 5.83** Number of children aged 6 to 12 diagnosed for the first time with Autism Spectrum Disorder, Manitoba, 2005/06-2008/09 and 2009/10-2012/13



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, Burchill C, Hu M, Rajotte L, Kulbaba C. The Mental Health of Manitoba's Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. [http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf) (Accessed August 19th 2017)

<sup>e</sup> A child (aged 0-19) is considered to have a diagnosis of ASD in either time period when he/she has met at least one of the following criteria in his/her lifetime:

- At least one hospitalization with a diagnosis of ASD; or
- At least one physician visit with a diagnosis of ASD or
- Received education funding for special needs.

#### 5.1.2.4 Fetal Alcohol Spectrum Disorder (FASD)

FASD is often not diagnosed until children reach school age, and begin to miss average behavioural and developmental milestones. At this stage, FASD is also often mistaken for other disorders, such as ASD or ADHD, which can result in less successful interventions, approaches and treatments due to misdiagnosis.<sup>148</sup>

Diagnosing FASD has benefits for children at any stage in their development, as commonly used parenting and education techniques may not work for children with FASD and can result in frustration for both the child and the adult. By having clear information about the disability, parents, teachers, and other professionals can provide appropriate interventions and advocate for effective supports for the child. Shifting from the perspective of “trying harder” to “trying differently” can help parents and those working with children with FASD look for ways to assist children to successfully learn, grow and adapt.<sup>149</sup>

#### 5.1.3 Oral Health

Good oral health is important for children to eat, speak, and relate to each other without embarrassment, pain, or infection, all of which affect people’s ability to fully function in society. Active dental caries are associated with pain, missing school and interfere with eating, smiling and sleeping. Children who have poor oral health are more likely to miss school and are more than twice as likely to have problems succeeding at school.<sup>150</sup>

Access to dental care is not universal. Children without dental insurance are 3 times more likely not to visit a dentist every year and are 6 times more likely to only seek dental care on an emergency basis.<sup>148</sup> While 5% of Canadian children in the highest income quintile were likely to experience dental pain in the last year, 15% of children in the lower middle or lowest income groups experienced dental pain.<sup>150</sup>

According to the Aboriginal Peoples Survey, in 2012, 95% of Indigenous children aged 6 to 14 contacted a dental professional in the previous year.<sup>151</sup>

#### 5.1.4 Immunization

Infectious diseases were at one time a leading cause of childhood death. Now they account for less than 5% of deaths. Immunization has contributed to that and has been one of the most successful public health measures implemented in the last century.<sup>31</sup> At age 7, two-thirds of Manitoba’s children have had the recommended immunization for diphtheria, tetanus and pertussis; 70% of 11-year-olds have had these immunizations. 92% have had the recommended immunization for mumps and rubella and 90% of 11-year-olds have been immunized against these diseases (Table 5.2).

**Table 5.2 Per cent of 7 and 11-year-olds who have had the recommended immunizations, Manitoba, 2014**

	Diphtheria	Tetanus	Pertussis	Polio	HiB	Pneu-C-13	Measles	Mumps	Rubella	Varicella
7 years	67	67	67	92	84	89	75	92	92	84
11 years	70	70	70	87	83	29	79	90	90	51

Data Source: Manitoba Immunization Monitoring System Annual Report 2014.

<http://www.gov.mb.ca/health/publichealth/surveillance/mims/index.html> (Accessed July 24, 2017)

Notes: Pneu-C-13 = Pneumococcal conjugate 13 vaccine. HiB = Haemophilus Influenza Type b.



By age 11, 80% of Manitoba children have had the recommended Meningococcal conjugate C (Men-C-C) vaccine and 71% have had Hepatitis B vaccine.<sup>88</sup>

In Manitoba in 2014, 62% of 7-year-olds had received the required doses of vaccine to be considered complete for their age. Northern Health Region had the highest rate at 74%, followed by Prairie Mountain Health (73%). Winnipeg RHA had the lowest percentage of children with complete immunizations for age overall at age seven 57%. There was considerable variation in uptake between the regions; the range between the highest and lowest uptake rate was approximately 15%. In 2014, eight in ten of Manitoba's 11-year-olds were considered complete for age for Men-C-C, while approximately seven in ten (71%) of 11-year-olds were considered complete for age for the hepatitis B immunogen. Prairie Mountain Health had the highest percentage of 11-year-olds complete for age (86%) for Men-C-C, with Interlake-Eastern a close second (83%). Southern Health/Santé Sud had the lowest percentage of children complete for age for Men-C-C (74%). In Manitoba, 71% of 11-year-olds were complete for age for the hepatitis B immunogen in 2014; that is, they received the complete hepatitis B vaccine series (three doses) before their eleventh birthday. Prairie Mountain Health had the highest percentage (78%) and Northern Health Region had the lowest percentage (66%). The remaining three RHAs had approximately seven out of ten 11-year-olds complete for age.<sup>88</sup>

## **5.1.5 Physical Activity and Overweight/Obesity**

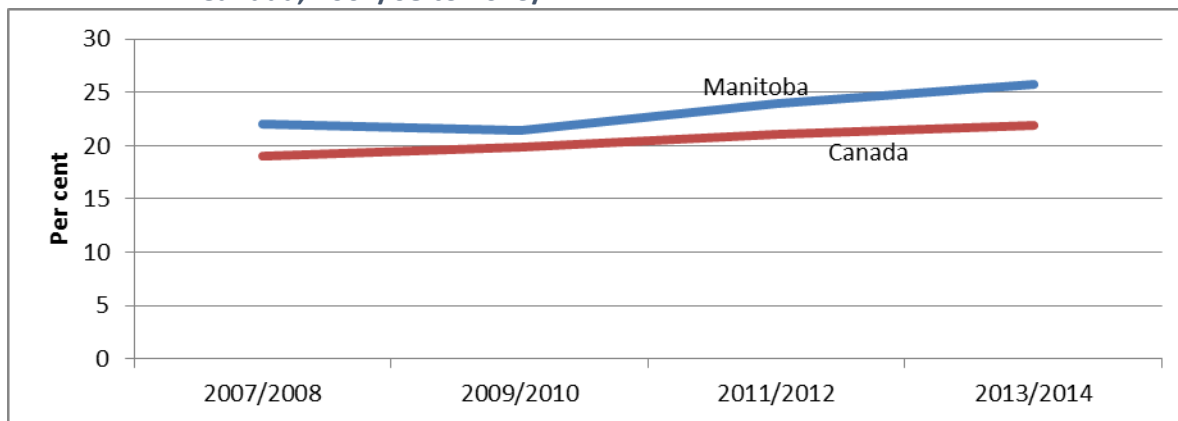
### *5.1.5.1 Obesity*

Obesity rates among Canadian children and youth have nearly tripled over the last 30 years.<sup>152</sup> The longer a child remains overweight, the greater the likelihood the child will remain overweight into adulthood.<sup>153</sup> half of overweight children in elementary school continue to be overweight adults.<sup>154</sup> Children who are overweight and obese are more likely to develop health problems, both as children and youth and into adulthood. These include high blood pressure or heart disease, stroke, Type 2 diabetes, sleep apnea, bone and joint problems, menstrual problems and certain types of cancer.<sup>31</sup> They are also more likely to develop emotional and/or mental health problems such as feeling judged, being teased or bullied, low self-esteem and depression.<sup>31</sup> The rate of overweight (including obese) children and youth is also higher in lower socioeconomic neighbourhoods.<sup>155</sup>

According to the 2012 Manitoba Youth Health Survey, 69% of Grade 7 and 8 students are within the healthy weight category for their age and weight, that is, not overweight or obese.

According to recent Canadian data, 26% of Manitoba children and youth aged 12 to 19 were either overweight or obese in 2013/14, an increase from 22% in 2007/08. The proportion of Manitoba children and youth who are overweight or obese is higher than that of the overall Canadian youth population (Figure 5.84).

**Figure 5.84 Proportion of 12- to 19-year-olds who are overweight or obese, Manitoba and Canada, 2007/08 to 2013/14**



Source: Statistics Canada. Table 105-0502 - Health indicator profile, two year period estimates, by age group and sex, Canada, provinces, territories, health regions (2013 boundaries) and peer groups, occasional (accessed: September 26, 2017) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1050502&p2=33>

#### 5.1.5.2 Body Mass Index (BMI)

Body Mass Index is a method of classifying body weight according to health risk. BMI is calculated by dividing body weight (in kilograms) by height (in metres) squared.

According to the Aboriginal Peoples Survey, in the years 2011 to 2014, 30% of Manitoba First Nations youth 12 to 24 years were overweight or obese according to self-reported BMI. That rate was 24% for Métis youth in the same age group.<sup>156</sup>

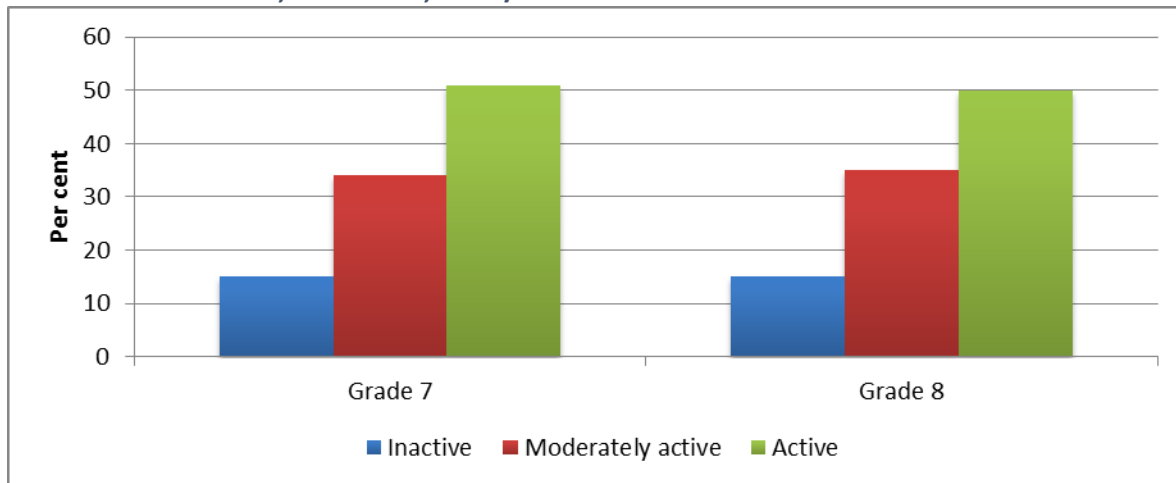
#### 5.1.5.3 Physical activity

In middle childhood, children begin to establish patterns of activity and eating, which can continue throughout their lives and lead to increased or decreased risks of chronic illnesses. Physical activity has a positive impact on both physical and mental health. Being physically active reduces the risk of chronic illnesses, reduces stress, improves self-esteem, and generally increases well-being and quality of life.<sup>31</sup>

Being active for at least 60 minutes a day can improve health and well-being in a number of ways: it increases fitness and strength, influences mood, positively affects academic performance, self-confidence, skill development and helps maintain a healthy weight.<sup>157</sup> Canadian Physical Activity Guidelines recommend that children aged 5 to 17 engage in 60 minutes of moderate to vigorous physical activity daily including biking, playing, running or swimming.<sup>31</sup>

In 2012/13, 51% of Grade 7 students in Manitoba reported being physically active for at least 60 minutes every day. That was the case for 50% of Grade 8 students. Of Grade 7 and 8 students, 15% were inactive (Figure 5.85).

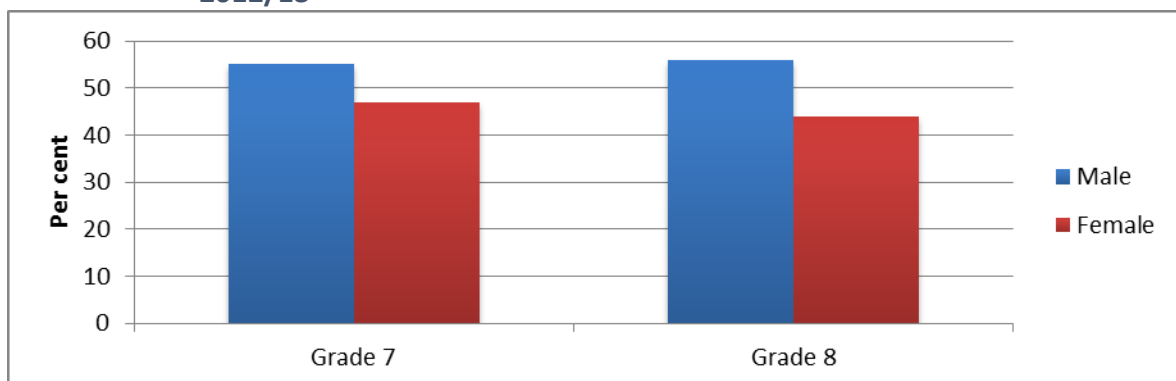
**Figure 5.85 Per cent of youth in Grades 7 and 8 who are inactive, moderately active and active, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017. Notes: Based on reported vigorous and moderate physical activity, students were placed in one of three categories: active, moderately active, or inactive. Students in the active category reported approximately 60 minutes of physical activity on a daily basis.

In both Grades 7 and 8, boys were more likely than girls to be active, and the difference increased with each grade (Figure 5.86).

**Figure 5.86 Per cent of youth in Grades 7 and 8 who are active, by gender, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017. Notes: Based on reported vigorous and moderate physical activity, students were placed in one of three categories: active, moderately active, or inactive. Students in the active category reported approximately 60 minutes of physical activity on a daily basis.

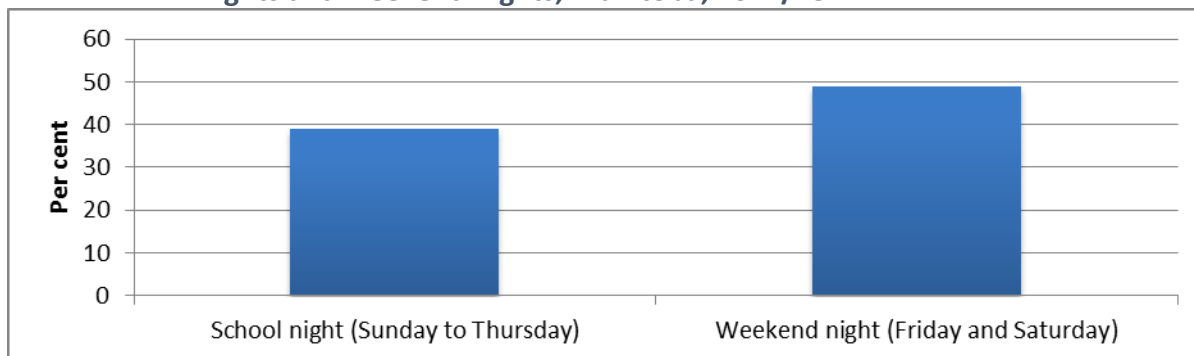
### 5.1.6 Sleep

Sleep is an important contributor to healthy physical and emotional development and growth in middle childhood. School-aged children who do not get enough sleep or have interrupted sleep patterns are more likely to have mental health problems. Studies have shown that children who are sleep deprived are more likely to be hyperactive and may find it difficult to concentrate and retain information, thus affecting their performance in school. Lack of sleep also increases the risk of accidents and injury, and may affect social relationships.<sup>158</sup> Further, consistent short sleep duration may be associated with a higher risk of obesity among children.<sup>159,160</sup>

Youth require 9 to 9 1/2 hours of sleep per night, but the actual sleep time for this group is less.<sup>161,162</sup>

In Manitoba, less than 40% of Grade 7 and 8 youth get 9 or more hours of sleep each school night, but nearly 50% of these youth receive 9 or more hours of sleep during weekend nights (Figure 5.87).

**Figure 5.87 Per cent of youth in Grades 7 and 8 who get 9+ hours of sleep a night, school nights and weekend nights, Manitoba, 2012/13**



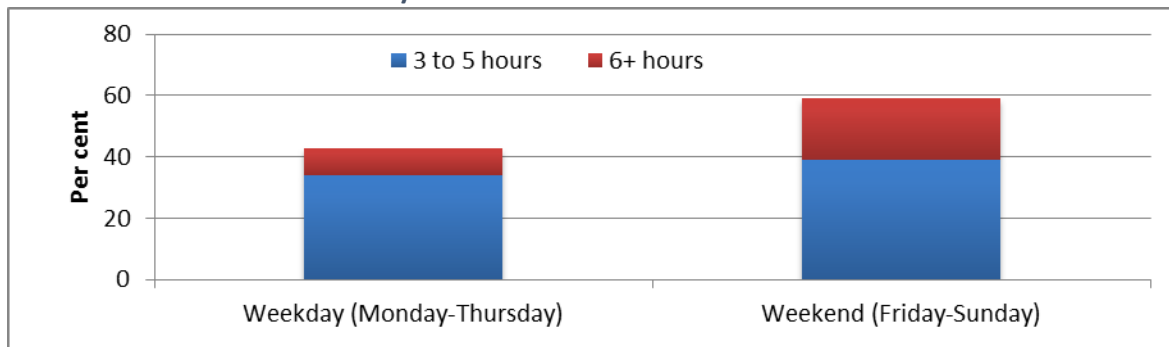
Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

### 5.1.7 Screen Time

There are a number of factors that contribute to health problems among youth such as declining levels of fitness and nutrition, sleeping problems and overweight/obesity.<sup>163,164</sup> These include screen time, time being sedentary watching movies or TV, playing computer or video games, chatting, text messaging, engaging in social media (e.g., Instagram, Twitter), and surfing the web. It is recommended that young people limit recreational screen time to 2 hours or less per day to reap positive health outcomes.<sup>165</sup>

The proportion of youth in Grades 7 and 8 in Manitoba in 2012/13 who reported 3 or more hours of screen time was over 40% on weekdays and nearly 60% on weekends (Figure 5.88).

**Figure 5.88 Weekday and weekend screen time per week, youth in Grades 7 and 8, Manitoba 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

Note: The question is: In a typical week, mark how many hours (outside of school) you spend in front of a screen, for example, watching TV/movies, playing video/computer games, chatting, text message and surfing the internet (e.g., Facebook, Twitter, etc.).

However, the media plays an important role in children’s lives. School-aged children watch a lot of television, and are technologically savvy, accessing the internet in increasing numbers. According to Statistics Canada, Canadian parents of children ages 6 to 11 reported that their children had an average of 2.5 hours of screen time per day, 25% higher than the recommended amount. Directly measured sedentary time (measured with an accelerometer) was considerably higher, at an average of 7.6 hours a day.<sup>166</sup> In addition to affecting children’s physical health, screen time may also affect their emotional health and safety, by exposing them to violence, and making them vulnerable to predators, bullying and harassment on the internet.<sup>167</sup> Screen time has also been linked with sleep deprivation,<sup>168</sup> which worsens both physical and emotional health.

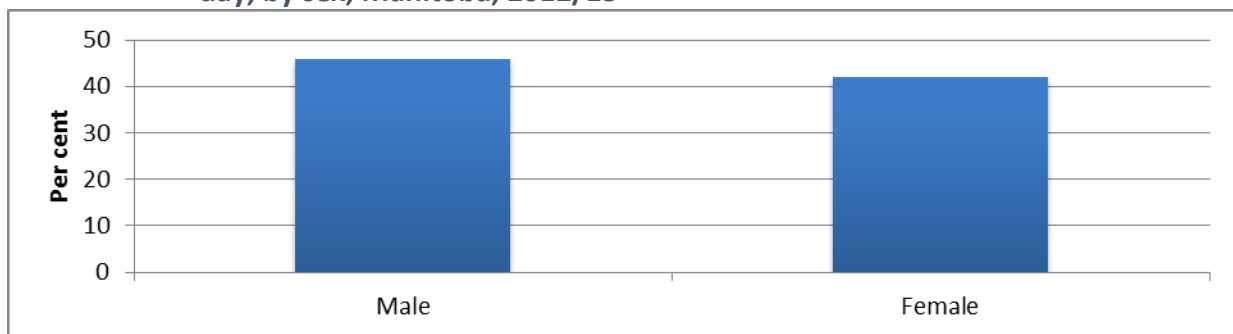
### 5.1.8 Healthy Eating

Healthy eating is important for healthy child development across all developmental stages. It contributes to optimal growth and cognitive development; positive academic performance and reduces the risk of becoming overweight or obese and developing chronic illnesses later in life.

Eating fruits and vegetables regularly is important for health and reduces the risk of becoming overweight and obese and of developing illnesses such as heart disease, stroke and cancer.<sup>169,170</sup>

In Manitoba in 2012/13, 46% of boys and 42% of girls in Grades 7 and 8 reported that they ate vegetables and fruit 7 times or more per day (Figure 5.89).

**Figure 5.89 Per cent of Grade 7 and 8 students who eat vegetables and fruit 7+ times per day, by sex, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017. Notes: Vegetables and fruit include fruit (not counting fruit juice), green salad, carrots, potatoes (not including French fries or potato chips), and other vegetables.

Regularly eating fast and pre-prepared/instant foods can lead to health problems. Those do not usually follow recommended portion sizes, tend to be higher in fat, sodium, sugar and calories, and have lower nutritional value.<sup>171</sup>

Undernutrition is also a problem that has been linked to higher prevalence of obesity, overweight, diabetes, hypertension and increased incidence of heart attack and stroke. Having access to healthy foods is important throughout our lives and the effects of under nutrition in parents and even grandparents can have an impact on the overall health of children for generations.<sup>172</sup>

For example, infants born to women whose obesity and diabetes arose as a result of childhood under nutrition are more likely to experience intrauterine growth failure, low and high birth weight and growth faltering.<sup>173</sup>

One of the most consistent themes in testimony provided to the Truth and Reconciliation Commission of Canada (TRC) was the experience of hunger at Residential Schools. This level of hunger and malnutrition had substantial consequences for a child's growth and development. In light of recent evidence showing the connections between childhood hunger and chronic disease risk in adulthood, we can be fairly certain that the elevated risk of obesity, early-onset insulin resistance and diabetes observed among Indigenous peoples in Canada may be attributed to the prolonged malnutrition experienced by many residential school survivors,<sup>173</sup> and the resulting intergenerational effects for their children.

## 5.2 Mentally Healthy

Parents and family continue to have an important influence on children's mental health in middle childhood, as do relationships with peers and other adults in the school and community. It is during middle childhood, when children begin school and are frequently monitored and evaluated, that mental health and behavioural issues such as anxiety disorders, depression, ADHD, and aggression are more frequently recognized and addressed. Mental health problems in middle childhood can lead to many other difficulties for children, such as the increased risk of dropping out of school, unemployment, poverty, homelessness and addiction.<sup>174</sup>

### Parental and Family Influences

Positive, stable, and nurturing relationships are essential to healthy development in middle childhood, contributing to children's sense of security and self-esteem. Positive parenting, an important influence on emotional health in early childhood, continues to be important in middle childhood, and can decrease the risk of children developing social and emotional problems.\*† Parental mental health, social supports, and family functioning are all important as well. A Canadian study found that higher levels of physical aggression and lower levels of prosocial behaviour were found in children whose mothers were depressed and used harsher methods of punishment.‡ As noted in *Chapter 4. Early Childhood (Birth to Age 5 Years)*, family functioning is associated with children's mental health, behavioural, and educational outcomes. Children in negative family environments tend to have an increased chance of social, emotional, and mental problems later in life.§||

\*Federal/Provincial/Territorial Advisory Committee on Population Health. (1999). *Toward a healthy future: Second report on the health of Canadians*. Ottawa: Health Canada.

†The Child and Adolescent Task Group of the F/P/T Advisory Committee on Population Health and Security. (2004). *Middle childhood: Taking action together*. Ottawa: Health Canada.

‡Romano, E., Tremblay, R.E., Boulerice, B., & Swisher, R. (2005). Multilevel correlates of childhood physical aggression and prosocial behaviour. *Journal of Abnormal Child Psychology*, 33, 565-578.

§Sameroff, A., Seifer, R., Zax, M., & Barocas, R. (1987). Early indicators of developmental risk: Rochester Longitudinal Study. *Schizophrenia Bulletin*, 13(3), 383-394.

|| Edwards, V.J., Holden, G.W., Felitti, V.J., & Anda, R.F. (2003). Relationship between multiple forms of childhood

### 5.2.1 Self-Reported Mental Health

The Manitoba Grade 5 Mental Health Survey (2016) asked students how they felt about their own mental health. Of Grade 5 students, 35% reported that their mental health was excellent and 30% said it was very good, while 9% reported that their mental health was fair or poor (Figure 5.90).

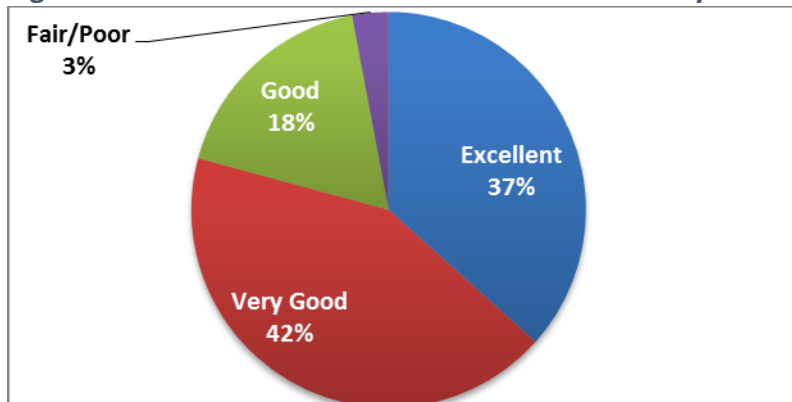
**Figure 5.90 Self-rated mental health of Grade 5 students, Manitoba, 2015/16**



Source: Healthy Child Manitoba. Manitoba Grade 5 Mental Health Survey Report. 2015/16  
Note: Student-completed assessment.

According to the Canadian Community Health Survey, 37% of 12- to 14-year-olds (Grades 7-9) in Manitoba rated their mental health as excellent and 43% rated it as very good; 3% rated it as poor/fair (Figure 5.91).

**Figure 5.91 Self-rated mental health of 12- to 14-year-olds, Manitoba, 2013/14**



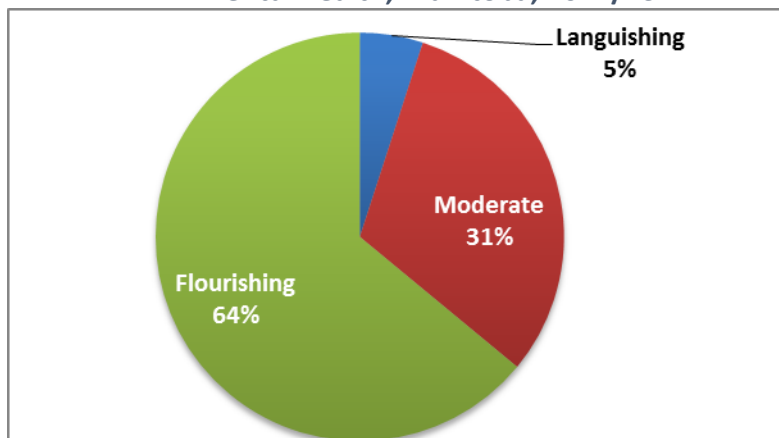
Source: Canadian Community Health Survey 2013/14. Public Use Data Set, Accessed through ODESI.

## 5.2.2 Mental Well-Being

According to the most recent Youth Health Survey in Manitoba (2012/13), the mental health of Manitoba youth was assessed as either languishing, moderate or flourishing using the 'Mental Health Continuum' scale. The scale is comprised of a series of questions related to mental health, for example if they felt happy, interested in or satisfied with their lives; their sense of belonging; relationships with family/peers; and other factors. If young people have anything less than flourishing mental health, it could be a potential warning sign for mental health problems in the future.<sup>157</sup>

In 2012/13, 64% of Manitoba youth in Grades 7-8 had flourishing mental health, 31% had moderate mental health and 5% had languishing mental health. This means that more than one-third were at risk of mental health problems in the future (Figure 5.92).

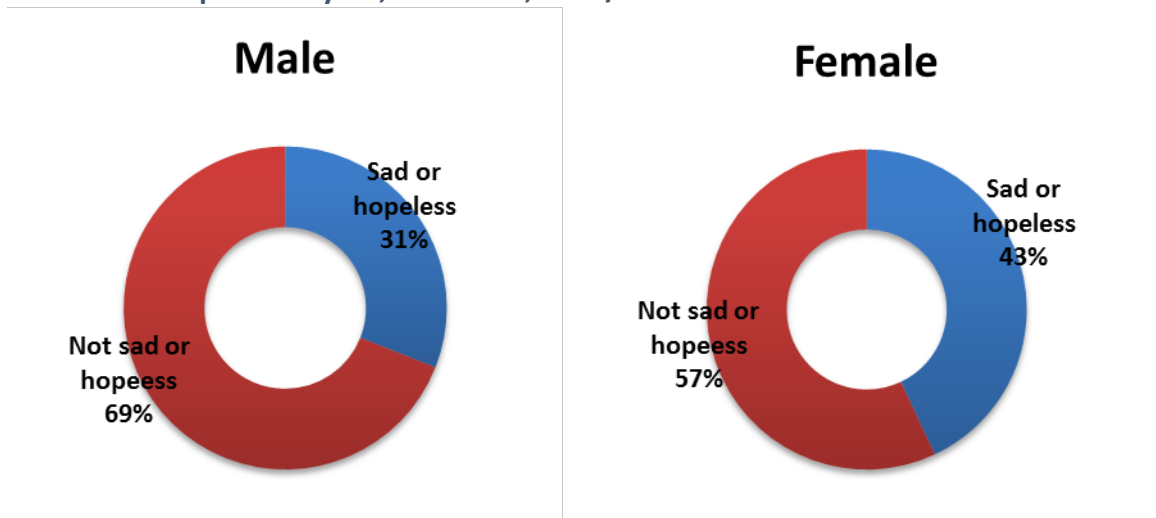
**Figure 5.92** Per cent of youth in Grades 7-8 who have languishing, moderate or flourishing mental health, Manitoba, 2012/13



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

In 2012/13, 43% of females in Grade 7-8 reported that they had felt so sad or hopeless in the previous year that they stopped doing their usual activities for a while, compared to 31% of males (Figure 5.93).

**Figure 5.93** Per cent of males and females in Grades 7 to 8 who felt sad or hopeless in the previous year, Manitoba, 2012/13



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

### 5.2.3 Anxiety and Mood Disorders

According to a recent report from the Manitoba Centre for Health Policy, anxiety and mood disorders include a broad group of disorders including depressive (depressed mood and lack of interest in activities), bipolar (elevated mood and increased energy), and anxiety disorders (excessive fear, anxiety or worry and often avoidance).<sup>f</sup> In 2005/06 to 2008/09 the four-year

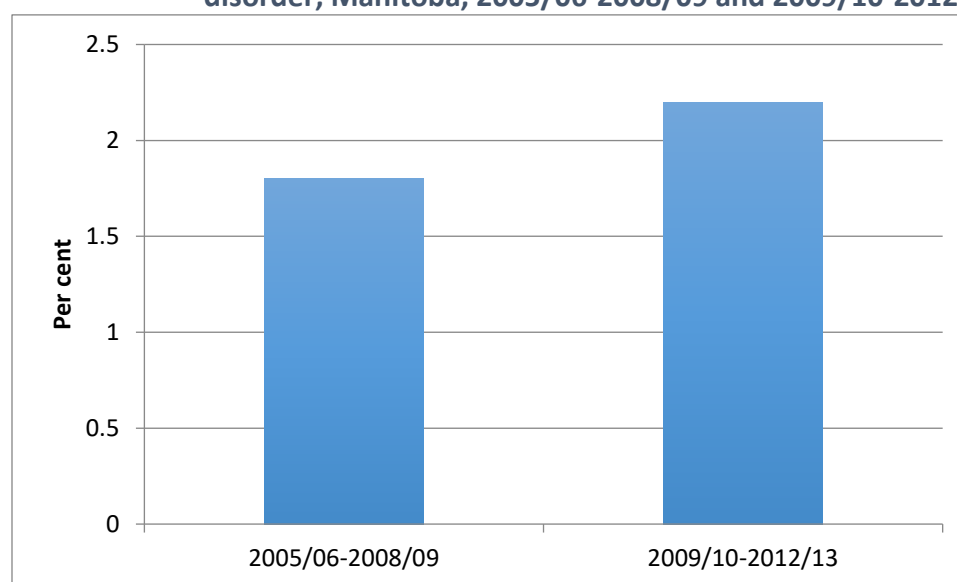
<sup>f</sup> In the MCHP report, a child (aged 6-19) is considered to have a diagnosis of mood and/or anxiety disorders in either time period when he/she meets at least one of the following criteria:



diagnosed prevalence of mood and anxiety disorders for children ages 6 to 12 was 1.8%. In 2009/10 to 2012/13, it had increased to 2.2% (Figure 5.94). The prevalence was highest in Winnipeg and lowest in the Northern Region. In 2005/06 to 2008/09, 1,744 children and youth ages 6 - 12 years were diagnosed for the first time with a mood/anxiety disorder. That number rose to 2,012 in 2009/10 to 2012/13.<sup>143</sup>

The prevalence of mood/anxiety disorders was higher in urban communities versus rural communities. Children living in lower-income quintile neighbourhoods (i.e., poorer neighbourhoods) were more likely to have a mood/anxiety disorder than are those living in higher-income quintile neighbourhoods (i.e., wealthier neighbourhoods).<sup>143</sup>

**Figure 5.94 Per cent of children and youth aged 6 to 12 diagnosed with mood/anxiety disorder, Manitoba, 2005/06-2008/09 and 2009/10-2012/13**



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, Burchill C, Hu M, Rajotte L, Kulbaba C. The Mental Health of Manitoba's Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. Retrieved on August 19th 2017 from: [http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf)

#### 5.2.4 Conduct Disorders

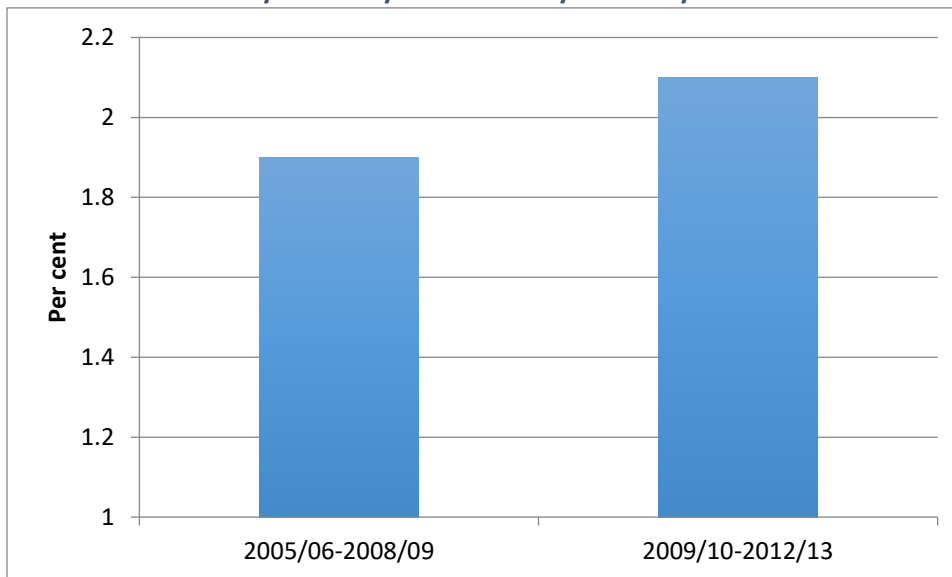
Children and youth with conduct disorders are engaged in antisocial, aggressive or defiant behaviour that is repetitive and persists.<sup>143</sup> This can include excessive fighting, bullying, destructiveness, cruelty, temper tantrums, lying and stealing.

- At least one hospitalization with any of the following diagnoses over four years: depressive disorder, affective psychoses, neurotic depression or adjustment reaction, anxiety state, phobic disorders, or obsessive-compulsive disorders;
- At least one hospitalization with a diagnosis of anxiety disorders AND one or more prescriptions for an antidepressant or mood stabilizer over four years
- At least one physician visit with a diagnosis of depressive disorder or affective psychoses over four years;
- At least one physician visit with a diagnosis of anxiety disorders AND one or more prescriptions for an antidepressant or mood stabilizer over four years; or
- Three or more physician visits with a diagnosis of anxiety disorders or adjustment reaction over four years"

In 2005/06-2008/09, the four-year diagnostic prevalence of conduct disorder<sup>§</sup> among children and youth ages 6 to 12 years was 1.9%, and in 2009/10-2012/13 it was 2.1% (Figure 5.95). Conduct disorder prevalence was higher in Winnipeg (2.5% in 2009/10-2012/13). In 2005/06 to 2008/09, 1,557 children and youth ages 6 to 12 years were diagnosed for the first time with a conduct disorder. That number rose to 1,725 in 2009/10 to 2012/13.<sup>143</sup>

The prevalence of conduct disorders was higher in urban communities versus rural communities. Children living in lower-income quintile neighbourhoods (i.e., poorer neighbourhoods) were more likely to have conduct disorder than were those living in higher-income quintile neighbourhoods (i.e., wealthier neighbourhoods).<sup>143</sup>

**Figure 5.95 Per cent of children and youth aged 6 to 12 with conduct disorder, Manitoba, 2005/06-2008/09 and 2009/10-2012/13**



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, Burchill C, Hu M, Rajotte L, Kulbaba C. The Mental Health of Manitoba's Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. Retrieved on August 19th 2017 from: [http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf)

### 5.2.5 Other Mental Health Problems

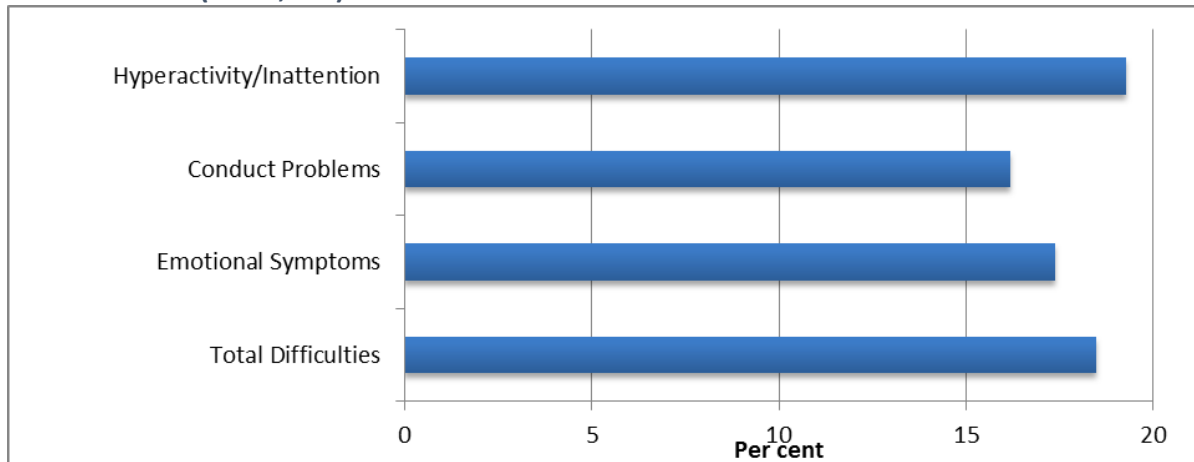
According to the Manitoba Grade 5 Mental Health Survey, 19% of students have at least some difficulty in an area of mental health: 19% have hyperactivity/inattention problems, 17% have at least some difficulty with emotional symptoms, and 16% with conduct problems (Figure 5.96).

<sup>§</sup> In the MCHP report, a child is considered to have a diagnosis of conduct disorder in either time periods if he/she meets at least one of the following criteria:

- At least one hospitalization with a diagnosis of conduct disorder; or
- At least one physician visit with a diagnosis of conduct disorder.

4 year prevalence refers to any diagnosis over a 4-year period (either 2005/06-2008/09 or 2009/10-2012/13). Lifetime prevalence (from child's birth to the age at the end of the study period [2012/13]) was calculated for developmental disorders and ASD.

**Figure 5.96 Per cent of Grade 5 students who have some difficulty, challenging issues or very challenging issues, by mental health problem, Manitoba, 2015/16 (N=10,281)**



Source: Healthy Child Manitoba. Manitoba Grade 5 Mental Health Survey Report. 2015/16.

Notes: **Emotional Symptoms:** often complains of headaches, stomach-aches or sickness; many worries or often seems worried; often unhappy, depressed or tearful; nervous in new situations, easily loses confidence; and many fears, easily scared. **Conduct Problems:** often loses temper; generally well-behaved, usually does what adults request; often fights with other youth or bullies them; often lies or cheats; steals from home, school or elsewhere. **Hyperactivity/Inattention:** restless, overactive, cannot stay still for long; constantly fidgeting or squirming; easily distracted, concentration wanders; thinks things out before acting; good attention span, sees work through to the end.

Youth may react to stress with internalizing behaviours where they react inwards, such as social withdrawal, or negative perceptions of self-worth. Or they may react with externalizing behaviours such as aggression or disruption. According to the student-completed information from the Manitoba Grade 5 Mental Health Survey, girls are more likely to have internalizing reactions to stress and boys are more likely to have externalizing reactions.<sup>175</sup>

### 5.3 Safe and Secure

#### 5.3.1 Safety

Increased mobility and independence in middle childhood result in increased vulnerability to injury and other risks both inside and outside the home. Safety in the home, neighbourhood, and school is important in order for children to thrive physically, mentally, academically, and socially.

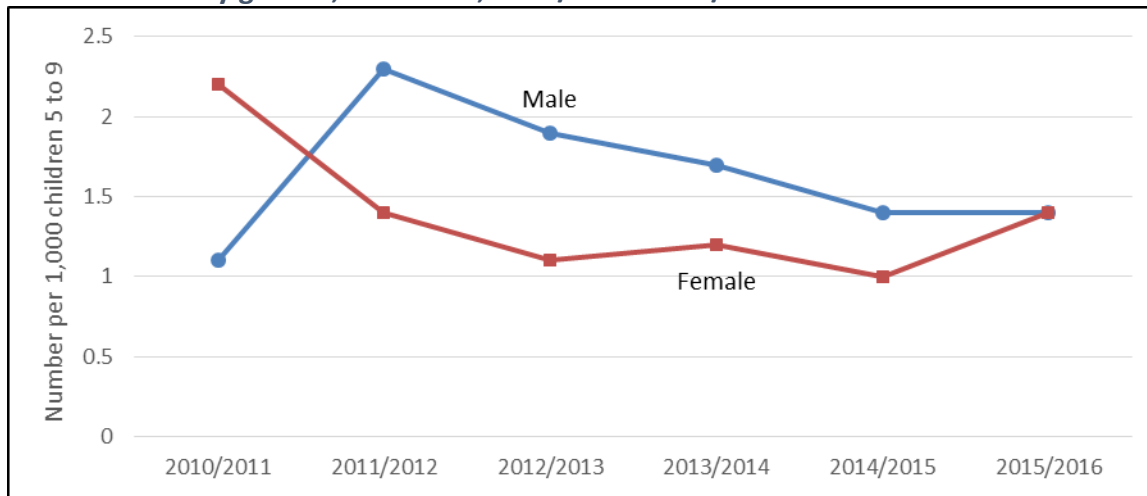
##### 5.3.1.1 Physical risks: Injury and mortality

###### *Injuries*

Injuries are a leading and preventable cause of health care utilization and death, and also pose a risk for both short-term and long-term disabilities.<sup>176</sup> Injuries remain a top cause of hospitalization and death for 5- to 14-year-old children in Manitoba. In this age group, most injuries are unintentional (accidental, e.g., falls, motor vehicle accidents).

In 2015/16, the injury hospitalization rate for both boys and girls aged 5 to 9 was 1.4 per 1,000 population. The rate declined slightly for boys and declined at a greater rate for girls between 2010/11 and 2015/16 (Figure 5.97).

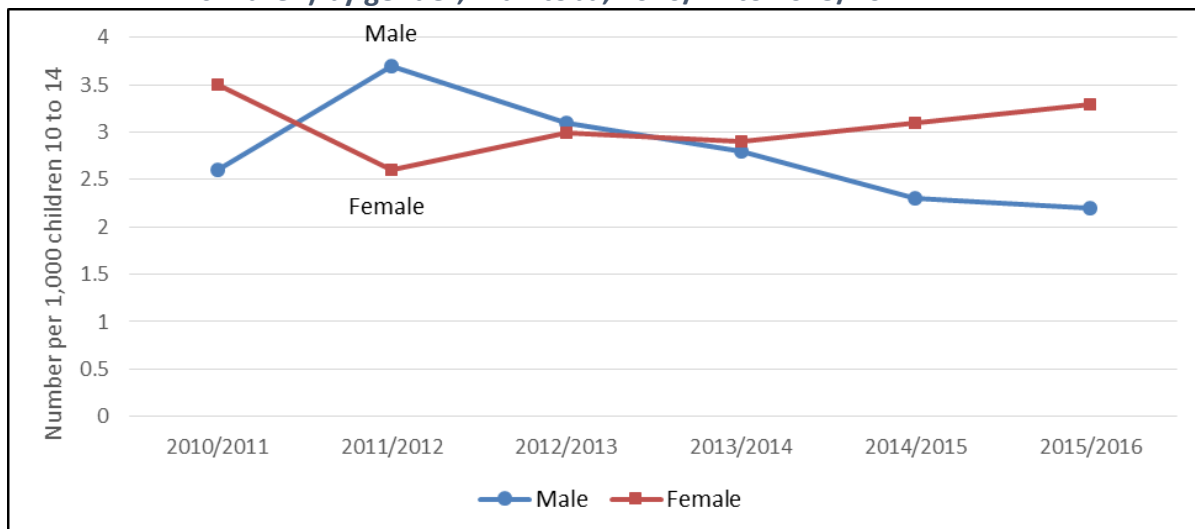
**Figure 5.97 Rate of injury hospitalization, children aged 5 to 9 (number per 1,000 children) by gender, Manitoba, 2010/11 to 2015/16**



Source: Manitoba Health, Seniors & Active Living Annual Statistics 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015. Retrieved from <http://www.gov.mb.ca/health/annstats/>

In 2015/16, the injury hospitalization rate for girls aged 10 to 14 was 3.3 per 1,000 population. For boys, the rate was 2.2 per 1,000 population. The rate declined for boys but not for girls between 2010/11 and 2015/16 (Figure 5.98).

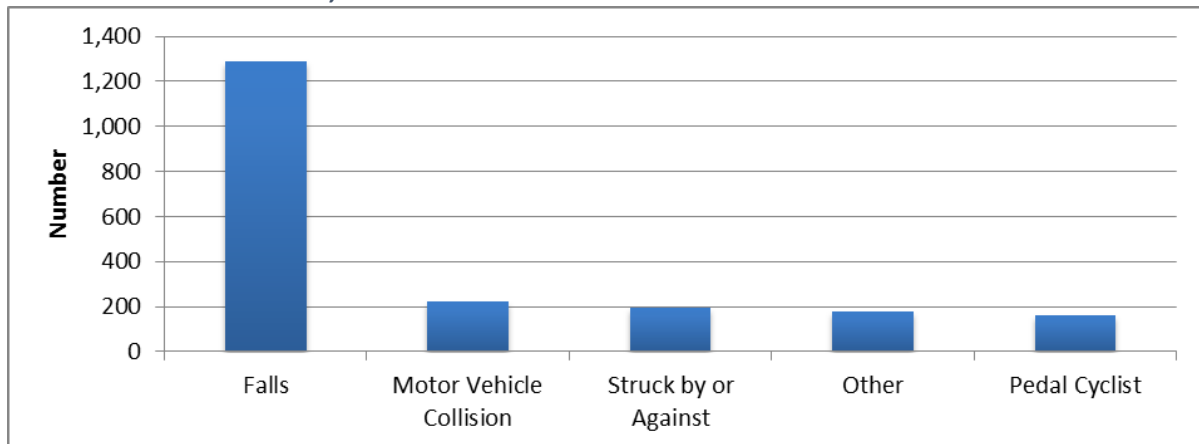
**Figure 5.98 Rate of injury hospitalization, children aged 10 to 14 (number per 1,000 children) by gender, Manitoba, 2010/11 to 2015/16**



Source: Manitoba Health, Seniors & Active Living Annual Statistics 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015. Retrieved from <http://www.gov.mb.ca/health/annstats/>

The leading cause of unintentional injury hospitalizations for children aged 5 to 9 years for the years 2000 to 2012 was falls. This was followed by motor vehicle collisions, being struck by an object, other and cycling (Figure 5.99).

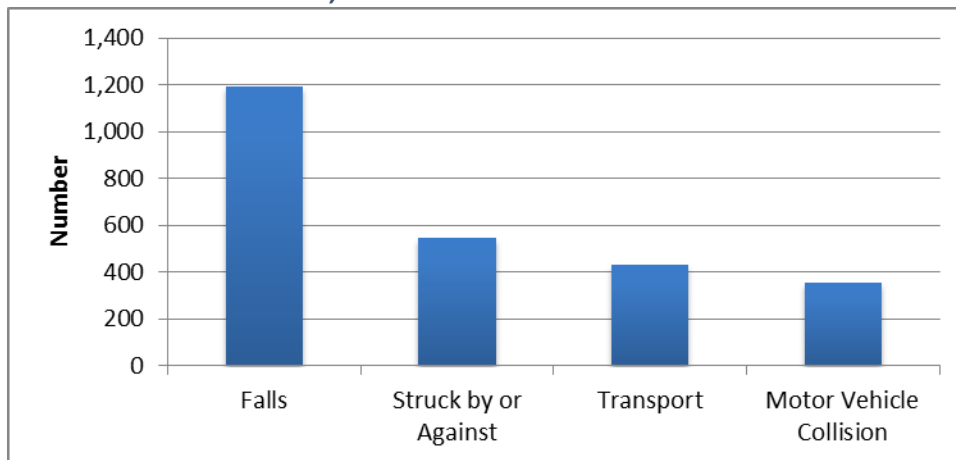
**Figure 5.99** Leading causes of unintentional injury hospitalizations, children 5 to 9 years, Manitoba, 2000-2012



Source: Injury Prevention Plan: Taking Steps to Prevent Injuries in Manitoba, Manitoba Health, Healthy Living and Seniors, June 2015. Retrieved from [https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury\\_prevention\\_plan.pdf](https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury_prevention_plan.pdf) Accessed July 24, 2017

The leading cause of unintentional injury hospitalizations for children ages 10 to 14 years for the years 2000 to 2012 was also falls. This was followed by being struck by an object, transport and motor vehicle collisions (Figure 5.100).

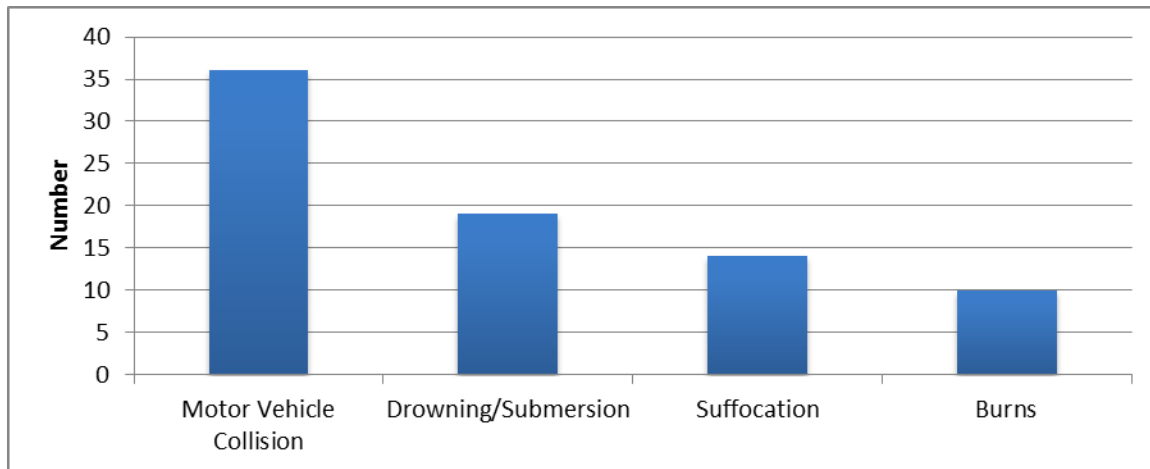
**Figure 5.100** Leading causes of unintentional injury hospitalizations, children 10 to 14 years, Manitoba, 2000-2012



Source: Manitoba Health, Seniors & Active Living Annual Statistics 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015. Retrieved from <http://www.gov.mb.ca/health/annstats/>

Although a relatively rare occurrence, childhood deaths do occur. In the years 2000 to 2012, the leading cause of unintentional injury death among children and youth was motor vehicle collision, followed by drowning. Motor vehicle collisions claimed the lives of 36 children and youth aged 5 to 14. Drowning caused 19 deaths (Figure 5.101).

**Figure 5.101** Leading causes of unintentional injury deaths, children aged 5 to 14, Manitoba, 2000-2012

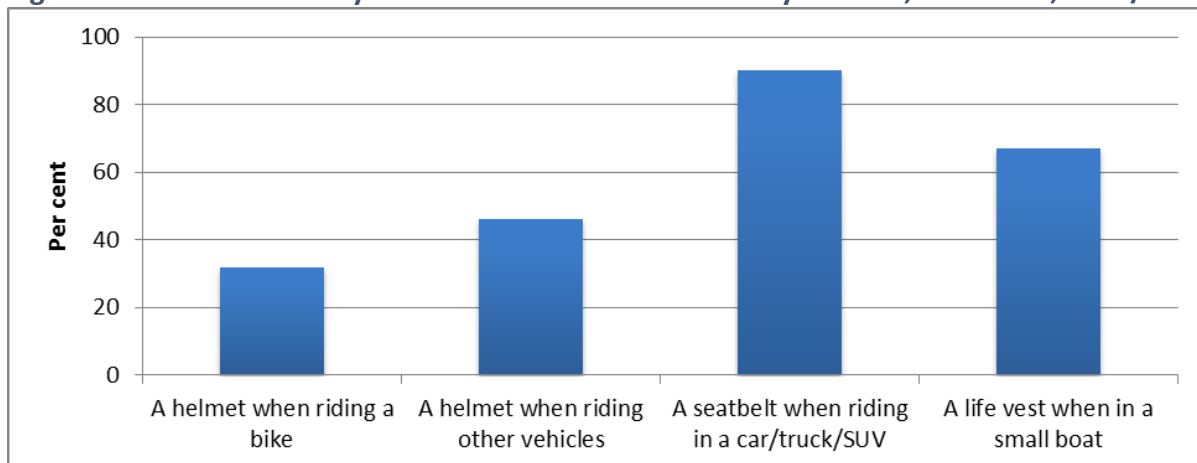


Source: Injury Prevention Plan: Taking Steps to Prevent Injuries in Manitoba, Manitoba Health, Healthy Living and Seniors, June 2015. Retrieved from [https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury\\_prevention\\_plan.pdf](https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury_prevention_plan.pdf)

Most injuries among children and youth are preventable. Certain actions can prevent unintentional injuries, such as using a helmet while cycling, riding snowmobiles, ATVs, dirt bikes and motorcycles; using a seatbelt; and using a personal flotation device while boating.

In 2012/13, 90% of youth in Grades 7-8 reported that they always wear a seatbelt when riding in a car, truck or SUV. However only 32% said they always wore a helmet when cycling and 67% said they always wore a life vest when in a small boat (Figure 5.102).

**Figure 5.102** Per cent of youth in Grades 7 to 8 who always wear..., Manitoba, 2012/13



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

### Crisis lines

Kids Help Line and other crisis services can be found in *Chapter 6: Youth (Ages 13 to 19/Grades 7 to 12)*.

### 5.3.1.2 *Safe families*

The home environment remains a central space in middle childhood. However, not all home environments are safe, and victimization or witnessing of violence does occur within the home or family. For information on Manitoba children in care of Child and Family Services, or receiving protection or support services from Child and Family Services, please refer to *Chapter 2: Who Are Manitoba's Children and Youth?*

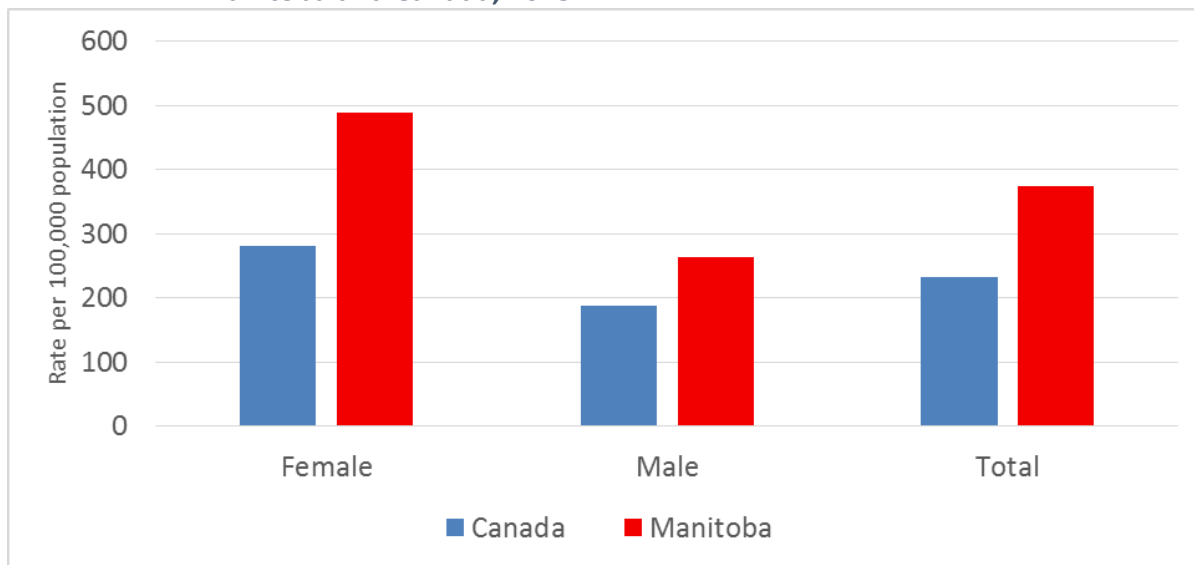
In Canada, among children ages 3 to 11 who are violently victimized (e.g., physically or sexually assaulted, threatened, etc.), almost half (47% in 2010) are victimized by someone within their own family network.<sup>114</sup> Over half (60% in 2009) of children ages 3 to 11 who are victims of police-reported family-related violence are assaulted by their parent.<sup>177</sup> There are important age and sex differences. For 3- to 11-year-old victims, family-related violence is more common than non-family-related violence for females, while non-family-related violence is more common for males. The leading contributor to the higher rates of family violence among girls, particularly as they get older, relates to their much higher risk of being sexual abused.

Child maltreatment is considered as a global public health concern. There are many negative short and long-term outcomes for victims that are associated with maltreatment.<sup>178</sup> These outcomes include poor school performance, delinquency, poor physical and mental health outcomes as well as experiencing further victimization in adulthood.<sup>179,180,181</sup>

It is difficult to measure child maltreatment presents. Relying on police-reported data may result in an underrepresentation, as children may not realize that what they are experience is criminal, may be afraid of the consequences or reporting, may not have the ability to report or lack the support to do so.<sup>182</sup>

Rates of police-reported family violence against children and youth in the provinces in 2015 was highest in Saskatchewan (465 per 100,000 population) followed by Manitoba (374) and lowest in Ontario (156). These rates are higher for violence against girls compared to boys (489 and 264, respectively, per 100,000 in Manitoba) (Figure 5.103).

**Figure 5.103 Child and youth victims (ages 0 to 17) of police-reported family violence, Manitoba and Canada, 2015**



Source: Family Violence in Canada: A statistical profile, 2015, Statistics Canada--Catalogue no. 85-002-X

Family violence is an important public health issue that goes beyond direct physical injury. Regardless of severity, family violence can affect health and have long-lasting effects, particularly for mental health. Family violence can take many forms and range in severity from neglect to physical, sexual, emotional, and financial abuse.<sup>183</sup> Family violence is more likely to affect those who are more vulnerable, marginalized, or facing inequities (e.g., women, children, Indigenous peoples, and people with disabilities).<sup>183</sup>

Family violence can take many different forms.

- **Physical abuse:** a physical act such as pushing, hitting, slapping, kicking, pinching, choking, stabbing, shooting, throwing objects or burning.
- **Sexual abuse:** any type of forced sexual activity or sexual coercion at any age. Any sexual contact with a child under the age of 16 years is a crime as is sexual activity that exploits children under the age of 18 years.
- **Emotional abuse:** words or actions to control, frighten or destroy someone's self-respect.
- **Financial abuse:** control or misuse of someone's money or property.
- **Neglect:** not providing basic needs (e.g., food, adequate clothing, health care, protection from harm).
- **Exposure to intimate partner violence:** when children are aware of intimate partner violence that is happening in their home.

Child abuse and maltreatment places children at risk of a number of difficulties, particularly in school. Nearly half (46%) of children who are abused have functioning issues, including academic difficulties (23%), depression/anxiety/ withdrawal (19%), and child aggression (15%). Other functioning issues included attachment issues (14%), Attention Deficit Hyperactivity Disorder (11%), and intellectual or developmental disabilities (11%).<sup>184</sup> Risk factors and stressors among primary caregivers of maltreated children include being a victim of domestic violence (46%), having few social supports (39%), and having mental health issues (27%).



For more information on the Family Violence Prevention Program of the Manitoba Government and the number of Manitoba children and youth under 18 years who accessed an emergency family violence shelter from 2012 to 2017, please see *Chapter 4: Early Childhood (Birth to Age 5 Years)*.

### 5.3.1.3 Safe neighbourhoods and schools

Having a positive neighbourhood environment is critical for children and youth. Children ages 6 to 12 spend a large part of their day outside of the home, interacting with peers and the broader community. They are beginning to explore the world around them and are doing so with less adult supervision. As a result, children need safe places to play and families need safe communities.<sup>166</sup> Neighbourhood quality (including neighbourhood cohesion,<sup>185</sup> neighbourhood problems, and neighbourhood safety) may be associated with conduct<sup>186</sup> and emotional disorders, hyperactivity, and non-sports related injuries in 4- to 11-year-olds.<sup>119</sup> When children have access to safe neighbourhoods, parks, and playgrounds, they are more likely to increase their participation in activities that contribute to healthy development, higher school achievement, and positive social behaviour.<sup>187</sup>

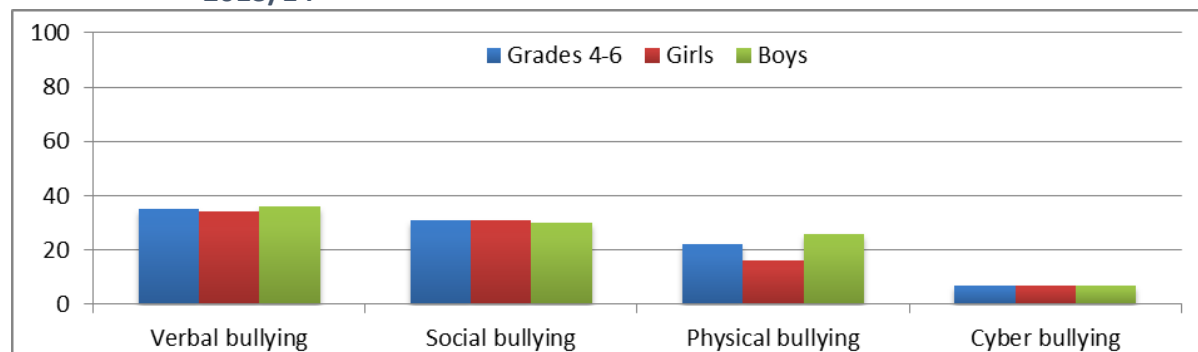
### 5.3.1.4 Safety at school/bullying

Bullying is a significant health problem for the children who are bullied and for the children who bully.<sup>31</sup> Children who are bullied commonly experience chronic stress.<sup>31</sup>

School bullying is associated with lower academic achievement, lower school satisfaction, and lower levels of school engagement. Victims of both cyber and school bullying were over 4 times more likely to experience depressive symptoms and over 5 times more likely to attempt suicide, compared to non-victims.<sup>188</sup>

Among Grade 4 to 6 students in Manitoba who responded to the Tell Them from Me survey in 2013/14, 35% experienced verbal bullying, 31% social bullying, 21% physical bullying and 7% cyber bullying. Boys were 1.6 times more likely than girls to experience physical bullying (Figure 5.104).

**Figure 5.104 Prevalence of bullying among youth in Grades 4 to 6, by gender, Manitoba, 2013/14**



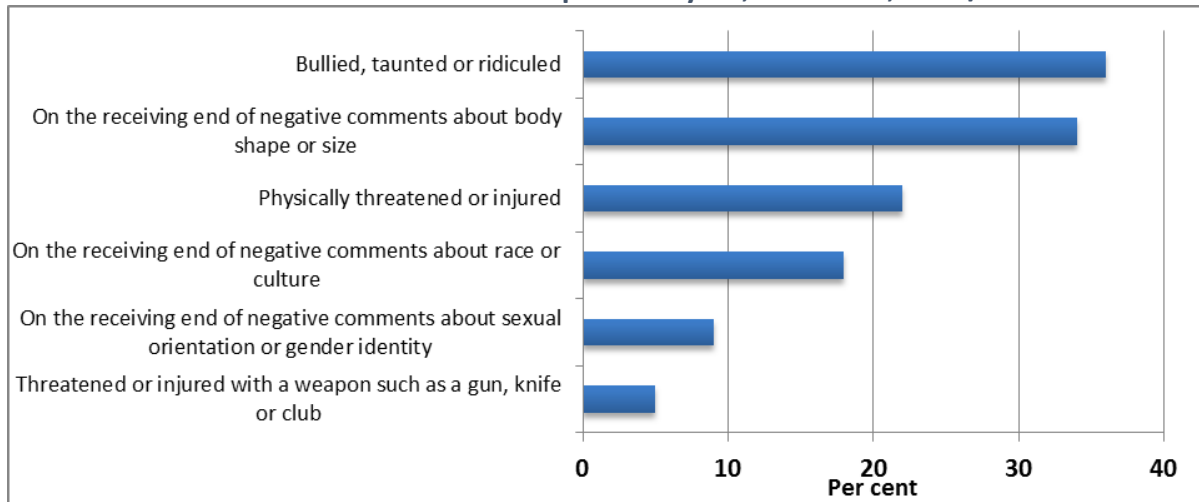
Source: Manitoba Education and Advanced Learning. Manitoba Provincial Report. Tell Them From Me: Bullying and School Safety. 2013/14. [http://www.edu.gov.mb.ca/k12/safe\\_schools/ttfm/full\\_doc.pdf](http://www.edu.gov.mb.ca/k12/safe_schools/ttfm/full_doc.pdf)

When asked how they responded when they were last bullied, 56% of students told their parent/guardian they were verbally, physically, socially or cyber bullied. Between 41% and 43%

told a teacher, depending on the type of bullying, 38% to 40% told a friend, 29% to 31% stood up to the bully, 27% to 29% ignored it, and 23% to 24% tried to talk to the bully.<sup>189</sup>

According to the Manitoba Youth Health Survey, in 2012/13, over one-third (36%) of Manitoba youth in Grades 7 and 8 reported that they had been bullied, taunted or ridiculed at least once in the previous year; 34% had received negative comments about their body shape or size; and 22% had been physically threatened or injured. Almost 1 in 5 (18%) had received negative comments about their race or culture (Figure 5.105).

**Figure 5.105 Per cent of youth in Grades 7 and 8 who have experienced bullying or personal threats at least once in the previous year, Manitoba, 2012/13**

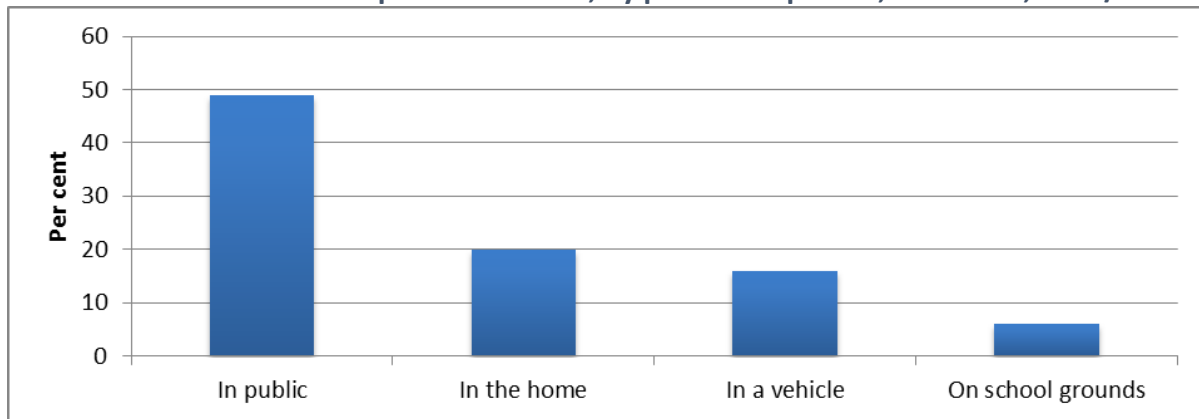


Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

Second-hand smoke exposure to second-hand smoke is a well-known risk for children. Children breathe more quickly than adults, therefore they take in more of the toxic chemicals in tobacco smoke. Their lungs are developing and more vulnerable. Their immune systems are also vulnerable. The risks from second-hand smoke include asthma, pneumonia, bronchitis, ear infections and coughing.<sup>190</sup> It is also associated with behaviour problems, sleep difficulties, an increased risk of cancer and a higher probability of starting to smoke themselves.<sup>191</sup>

The most common place that Grade 7 and 8 students in Manitoba are exposed to second-hand smoke is in a public place: 49% reported that they had been exposed in the month before they were surveyed. One in five are exposed at home (Figure 5.106).

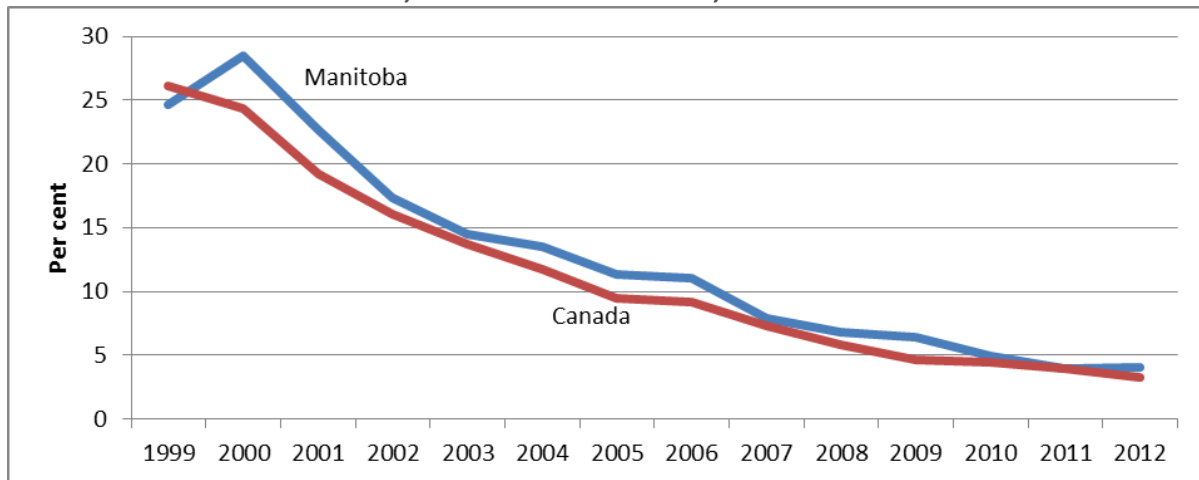
**Figure 5.106** Per cent of students in Grades 7 and 8 who were exposed to second-hand smoke in the previous month, by place of exposure, Manitoba, 2012/13



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

The likelihood that Manitoba children under 12 years of age are exposed to second-hand smoke at home is the same as that in Canada overall. Exposure at home has decreased over the last 15 years (Figure 5.107).

**Figure 5.107** Households with children under 12 years regularly exposed to second-hand smoke at home, Manitoba and Canada, 1999 to 2012



Source: Canadian Tobacco Use Monitoring Survey: overview of historical data, 1999 to 2012. <https://www.canada.ca/en/health-canada/services/publications/healthy-living/overview-historical-data-1999-2012.html#tab7> (Accessed October 5, 2017)

### 5.3.2 Security

Meeting the fundamental needs of school-aged children is essential to their healthy development. Basic necessities related to economic security include food, clothing and shelter. Emotional security is also important, and this is affected by the child’s relationships with family and significant others.

#### 5.3.2.1 Income security

*Chapter 2. Who Are Manitoba’s Children and Youth?* discusses the influence of income security, poverty and housing on children’s well-being. Statistics Canada provides three methods of low-income thresholds as measures of poverty (see section 2.7.1 for definitions). These include the

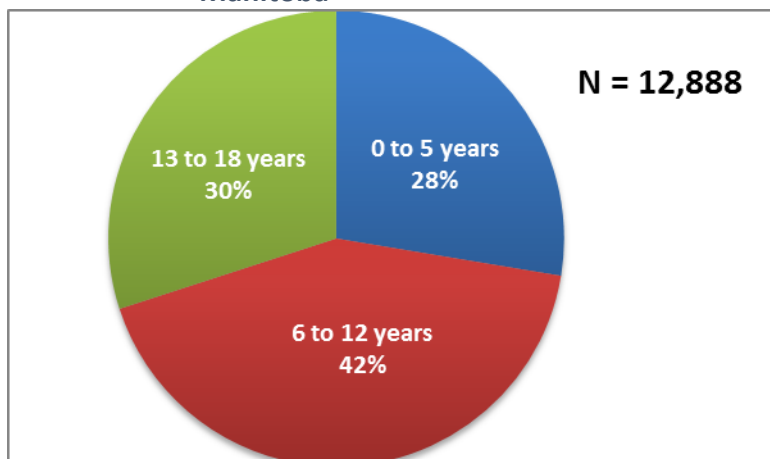
Market Basket Measure (MBM), the Low Income Measure (LIM) and the After-Tax Low–Income Cut-offs (After-Tax LICOs). According to the MBM, 16% of Manitoba children and youth under 18 lived in poverty in 2015. According to the LIM, 22% of Manitoba children and youth under 18 lived in poverty in 2015. According to the LICO-AT, 12% of Manitoba children and youth under 18 lived in poverty in 2015. For all three measures, the rate was higher in Manitoba than in Canada.<sup>192</sup> For more information on the three threshold measures, see *Chapter 2: Who Are Manitoba’s Children and Youth?*

In general, school-aged children living in poverty are more likely to have disabilities (including vision, hearing, speech, and mobility problems), chronic health problems, difficulties at school, emotional and mental health problems (including low self-esteem, aggression, and hyperactivity), and impaired social relationships.<sup>193</sup>

### 5.3.2.2 Housing security

Manitoba Housing rents affordable and suitable housing to Manitobans in need. Manitoba Housing administers and manages 13,794 rental housing units across the province and strives to provide quality housing at an affordable rent to individuals, seniors, and families. Manitoba Housing does not provide emergency housing. In 2017, 42% of children living in social housing units were 6 to 12 years of age (Figure 5.108).

**Figure 5.108 Children living in social housing unit by age group, as of February 9, 2017, Manitoba**

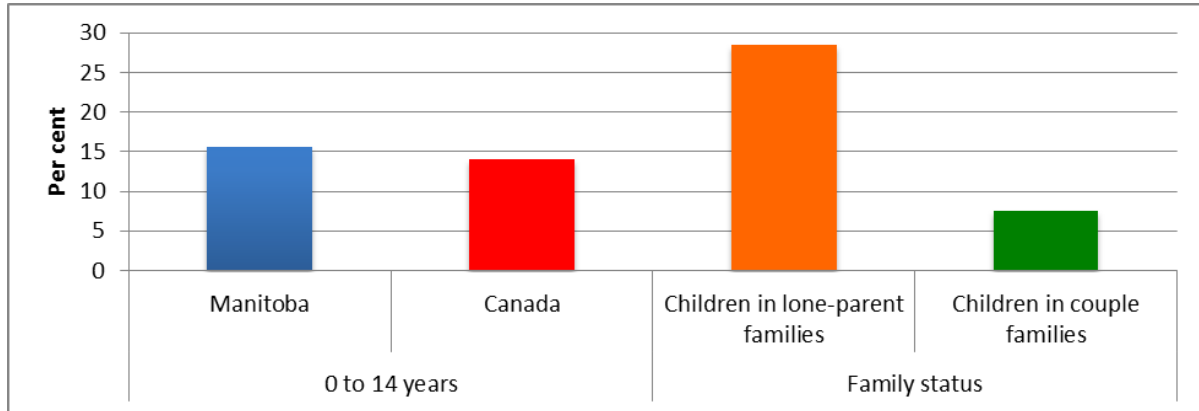


Source: Manitoba Housing Tenant Management System (TMS.) Query access: February 9, 2017

A household is said to be in core housing need if its housing falls below at least one of the adequacy, affordability or suitability standards and it would have to spend 30% or more of its total before-tax income to pay the median rent of alternative local housing that is acceptable (meets all three housing standards). These standards are as follows: adequate housing are reported by their residents as not requiring any major repairs, affordable dwellings costs less than 30% of total before-tax household income, and suitable housing has enough bedrooms for the size and make-up of resident households, according to National Occupancy Standard (NOS) requirements.<sup>194</sup>

In 2011, 16% of Manitoba children 14 years or younger lived in core housing need, compared to 14% for Canada overall. Children in lone-parent households were almost 4 times more likely than children in couple families to live in core housing need (Figure 5.109).

**Figure 5.109 Per cent of children living in core housing need, by age and family status, Manitoba and Canada, 2011**



Source: Core Housing Need Status for the Population, by Selected Characteristics and Gender, Canada, Provinces, Territories, Metropolitan Areas, 2011. [https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/data\\_025.cfm](https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/data_025.cfm)  
 Note: These data, from the National Household Survey, apply to all non-farm, non-band, non-reserve private households reporting positive incomes and shelter cost-to-income ratios less than 100 per cent.

As noted in *Chapter 2: Who Are Manitoba's Children and Youth?*, Indigenous Manitobans are almost 3 times more likely to live in core housing need than are non-Indigenous Manitobans.<sup>28</sup>

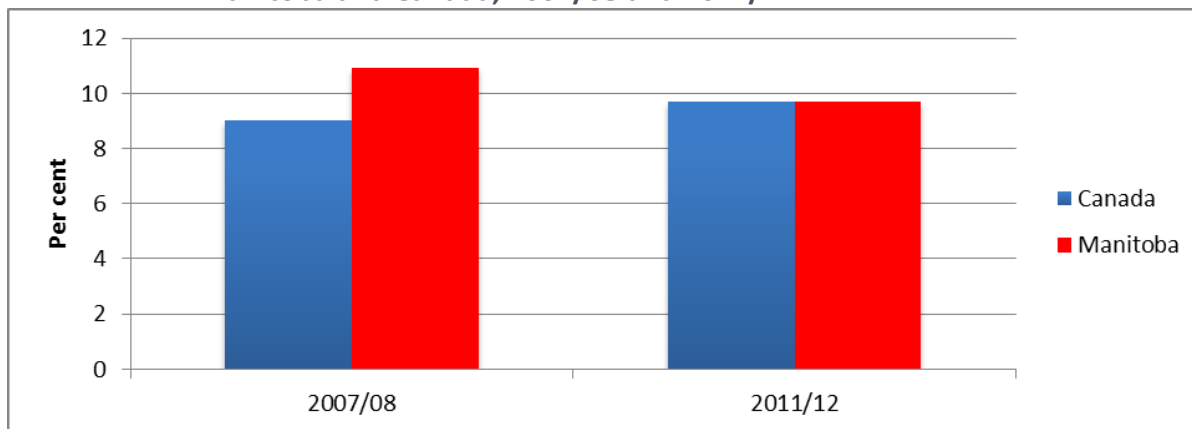
### 5.3.2.3 Food security

When families face food insecurity, they may not be able to eat the right kinds of foods to support and maintain their health. Children and youth in families who are food insecure may not have adequate healthy foods such as milk products and fruits and vegetables.<sup>195</sup>

When children experience hunger they are more likely to have health problems. If children suffer from hunger over time they are more likely to develop chronic conditions including asthma.<sup>196</sup>

In 2011/12, 10% of Manitoba children 6 to 17 years of age lived in households that were moderately or severely food insecure, down from 11% in 2007/08. The rate for Manitoba was higher than that for Canada in 2007/08 and the same in 2011/12 (Figure 5.110).

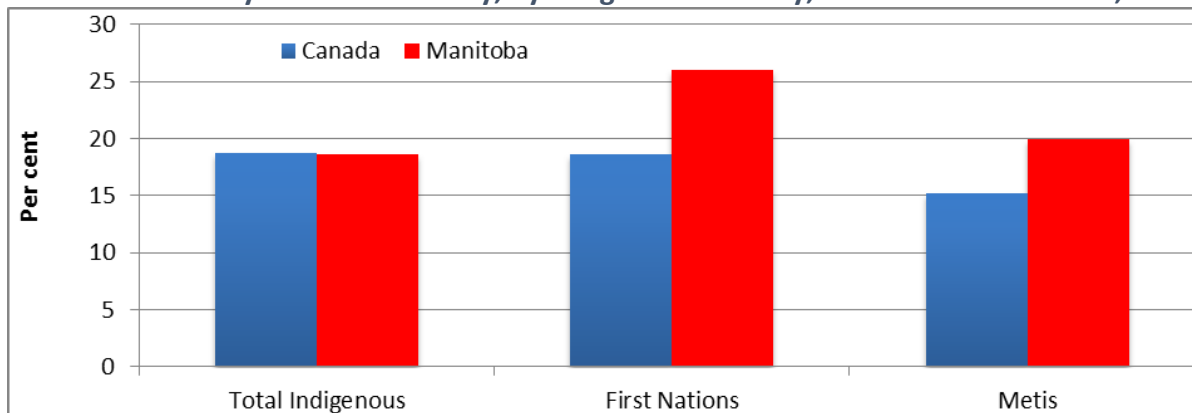
**Figure 5.110 Per cent of households with children ages 6 to 17 experiencing food insecurity, Manitoba and Canada, 2007/08 and 2011/12**



Source: Statistics Canada. Table 105-0546 - Household food insecurity measures, by presence of children in the household, Canada, provinces and territories. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1050546> (Accessed September 11, 2017)

In 2012, 19% of Indigenous households with children aged 6 to 14 reported that they had low or very low food security. That percentage was the same for Canada. In Manitoba, 26% of First Nations households with children ages 6 to 14 reported low or very low food security, as did 20% of Métis households, both notably higher than across Canada (Figure 5.111).

**Figure 5.111 Per cent of Indigenous households with children aged 6 to 14 reporting low or very low food security, by Indigenous identity, Manitoba and Canada, 2012**



Source: Statistics Canada. Table 577-0009 - Aboriginal peoples survey, food security, by Aboriginal identity, age group, sex, and number of persons in household, population aged 6 years and over, Canada, provinces and territories, occasional (accessed: September 27, 2017) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=5770010&pattern=&stByVal=1&p1=1&p2=-1&tabMode=dataTable&csid=>

Notes: Indigenous identity includes persons living off reserve who reported being an Aboriginal person, that is, First Nations (North American Indian), Métis or Inuk (Inuit) and/or those who reported Registered or Treaty Indian status, that is registered under the Indian Act of Canada, and/or those who reported membership in a First Nations or Indian band. The sum of the categories included in this variable is greater than the total population estimate for Indigenous identity because a person may have reported more than one Indigenous identity: for example, a person could self-identify as both First Nations and Métis. Numbers for Inuit (Inuk) too low to report.

#### 5.3.2.4 Emotional security and parenting

The way parents interact with their children can have a profound impact on children’s physical, mental, emotional, and social well-being. Positive parenting can significantly reduce the risk of children repeating a grade, as well as the risk of having an emotional or conduct disorder.<sup>197</sup> For children experiencing poverty, unsafe neighbourhoods, or physical or mental health problems, positive parenting can be a protective factor.<sup>198</sup> On the other hand, a negative family

environment, including inconsistent or harsh punishment, increases the risk of a child engaging in bullying behaviour.<sup>199</sup>

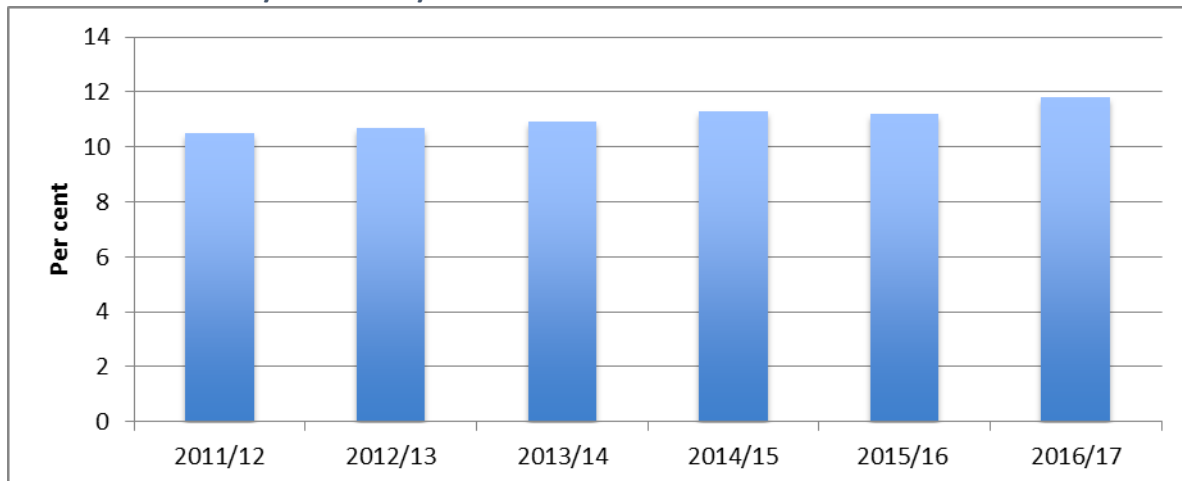
## 5.4 Successful at Learning

In middle childhood, children enter the structured learning environment of formal primary education. Children are exposed to new ideas and new experiences and are increasingly being evaluated in academic and social areas. Feedback from parents and teachers on academic performance becomes an important part of children's self-concept. Children also continue to learn outside of school from their experiences in their family and community environments.

### 5.4.1 Child Care

Many Manitoba families require child care for their children between 6 and 12 years of age, before or after school. In 2016/17, 12% of Manitoba children aged 6 to 12 had a regulated child care space. This was up from 11% in 2011/12 (Figure 5.112).

**Figure 5.112 Per cent of children ages 6 to 12 with a regulated child care space, Manitoba, 2011/12 to 2016/17**



Source: Manitoba Government, Child and Family Services Annual Report, 2007/08, 2008/09, 2009/10, 2010/11, 2011/12, 2012/13, 2013/14, 2014/15, 2015/16. Retrieved from [https://www.gov.mb.ca/fs/about/annual\\_reports.html](https://www.gov.mb.ca/fs/about/annual_reports.html)

### 5.4.2 Academic Learning

To ensure the best outcomes, schools have the challenging task of providing flexible and adapted learning programs to meet children's multiple educational and social needs. Continued efforts to keep children progressing in school are critical.

#### 5.4.2.1 Grade repetition

In cases where a student is struggling, some educators believe it is in the child's best interest to repeat the grade.<sup>200</sup> However, research suggests that students who repeat a grade are more likely to drop out of school,<sup>201</sup> or if they graduate are less likely to progress to post-secondary education.<sup>202</sup>

### 5.4.2.2 Numeracy and reading

The primary purpose of reading and numeracy assessments in Grades 3 and 4 are to improve student learning by identifying, early in the school year, students' strengths and needs in key competencies. By collecting the assessment information early in the school year, and reporting it to parents, educators can use it to plan next steps in students' learning and to support ongoing dialogue with parents to ensure that students have the foundational knowledge and skills needed to support learning across the curricula.<sup>203,204</sup>

The primary purpose of the middle years assessment is to enhance student learning and engagement through classroom-based assessment processes that build student awareness and confidence in learning. Research shows that both the quality and level of academic achievement and student engagement can be increased through formative assessment. Assessments take place for key competencies in mathematics, reading comprehension, expository writing, and student engagement.<sup>205,206</sup>

#### *Numeracy*

**Grade 3 Numeracy:** Early in the school year, teachers assess Grade 3 and 4 students in numeracy competencies. 2009/10 was the first year of province-wide assessment in Grade 3. A recent report measured Grade 3 numeracy with four different numeracy competencies: 1) predicts an element in a repeating pattern, 2) understands that the equal symbol represents an equality of the terms found on either side of the symbol, 3) understands that a given whole number may be represented in a variety of ways, and 4) uses various mental math strategies to determine answers to addition and subtraction questions up to the number. For each numeracy competency, students were categorized according to one of four levels of achievement for Grade 3 entry level performance standards: 1) meeting expectations, 2) approaching expectations, 3) needs ongoing help, and 4) out of range.<sup>h</sup>

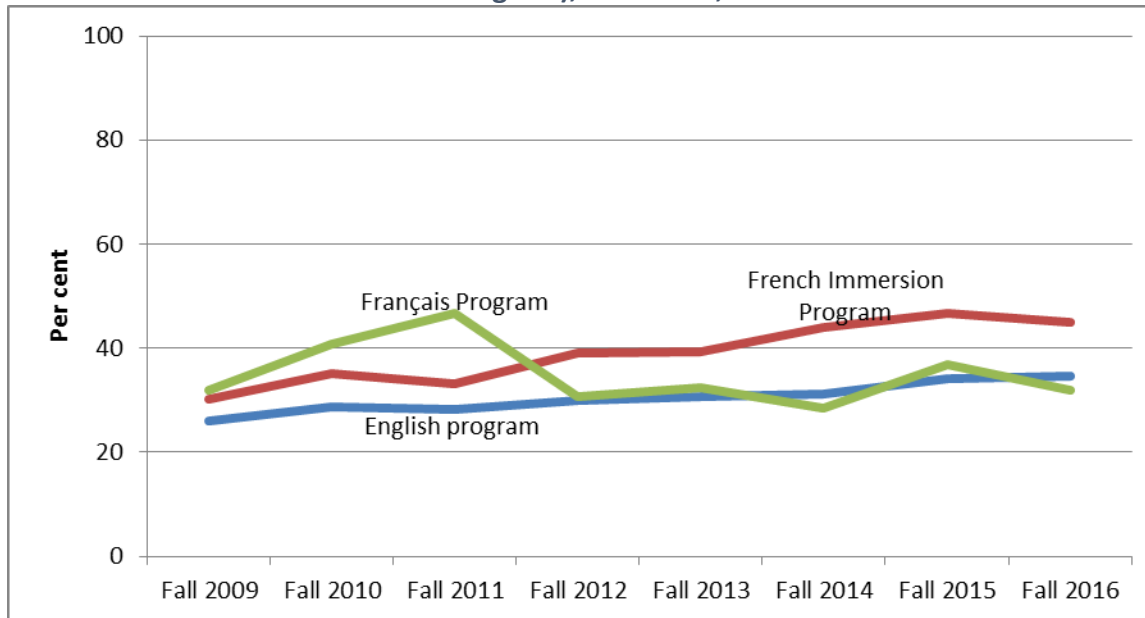
According to the Grade 3 Assessment in Numeracy, in Fall 2016, 35% of students in the English Program met expectations in all four competencies. The percentage was higher for children in the French Immersion Program at 45%. It was 32% for students in the Français Program. The percentage of students meeting expectations in all four competencies increased in the English Program and French Immersion Program between Fall 2009 and Fall 2016. In the Français Program, it increased from Fall 2009 to Fall 2011, with an overall decrease to Fall 2016 (Figure 5.113).

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<sup>h</sup> Used to describe those students who are working well below grade-level curriculum relative to the competencies assessed due to their learning disabilities or their need for new language learning.



**Figure 5.113** Per cent of students meeting expectations in all four competencies in the Grade 3 Assessment in Numeracy (English Program, Français Program, and French Immersion Program), Manitoba, Fall 2009 to Fall 2016

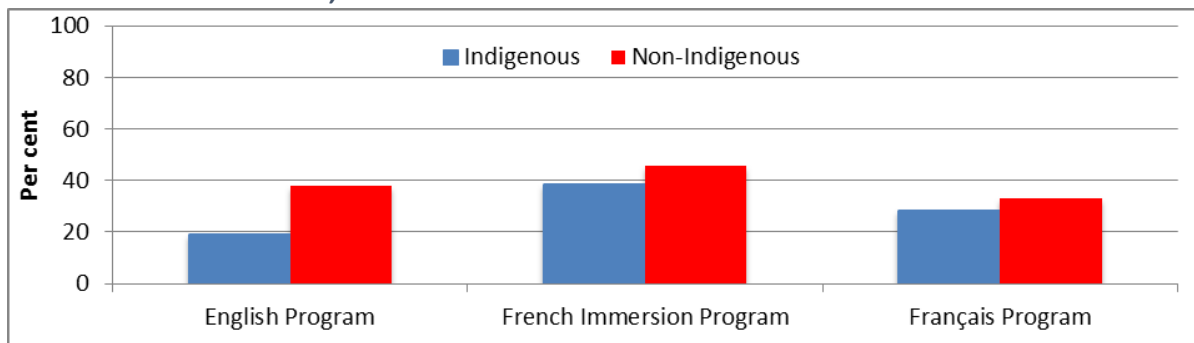


Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/) (Retrieved July 24, 2017)

In all three programs, boys were more likely to meet expectations in all four competencies in the numeracy assessment than were girls. In the English Program, 36% of boys did so versus 33% of girls. In the Français Program, 34% of boys met the competencies versus 30% of girls. In the French Immersion Program, those rates were 50% versus 41% respectively.<sup>207</sup>

In 2016, Indigenous students were less likely to meet expectations in all four competencies than were non-Indigenous students in all three programs (Figure 5.114).

**Figure 5.114** Per cent of students meeting expectations in all four competencies in the Grade 3 Assessment in Numeracy (English Program, Français Program, and French Immersion Program), Indigenous and non-Indigenous students, Manitoba, Fall 2016



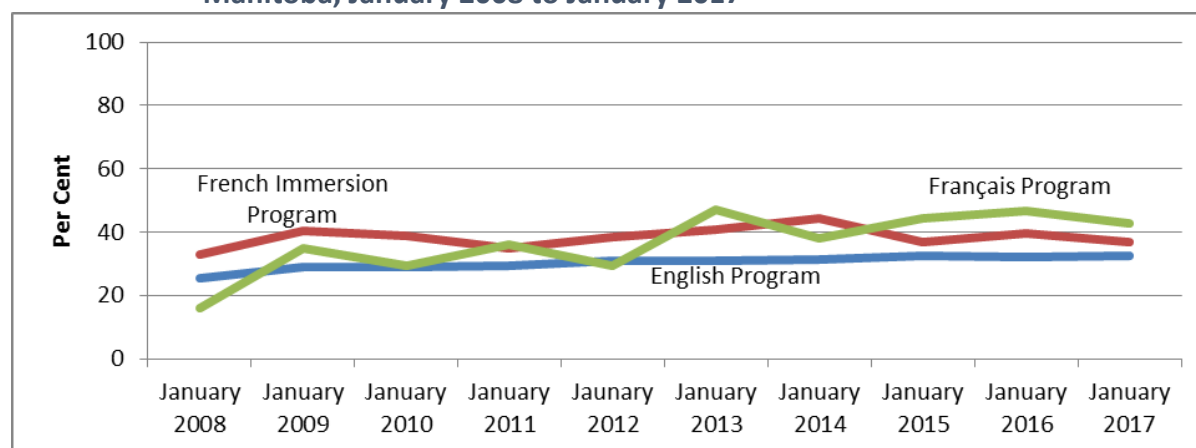
Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/) Retrieved July 24, 2017

In all three programs, the percentage of Indigenous students who met expectations in all four competencies increased between 2009 and 2016, from 15% to 19% in the English Program,

from 23% to 39% in the French Immersion Program, and from 25% to 28% in the Français Program.<sup>207</sup>

**Grade 7 Mathematics:** In January of each year since 2008, teachers assess the mathematics skills of Grade 7 students, including number sense and number skills. There are five competencies that are assessed.<sup>i</sup> In January 2017, 33% of Grade 7 students met the mid-grade performance expectations in all five competencies in the Middle Years Assessment in Mathematics. This was the case for 37% of French Immersion students and 43% of students in the Français Program. In all three programs, the percentage of students meeting the competencies increased from 2008 to 2017 (Figure 5.115).

**Figure 5.115 Per cent of Grade 7 students meeting mid-grade performance expectations in all five sub-competencies in the Middle Years Assessment in Mathematics (English Program, French Immersion Program and Français Program), Manitoba, January 2008 to January 2017**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/) Retrieved July 24, 2017

The percentage of girls and boys meeting the competencies was relatively equal in the English Program in 2017 (34% of girls and 32% of boys) and the French Immersion Program (36% of girls and 38% of boys). However, in the Français Program, 46% of girls met the mid-grade performance in competencies compared to 39% of boys.<sup>207</sup>

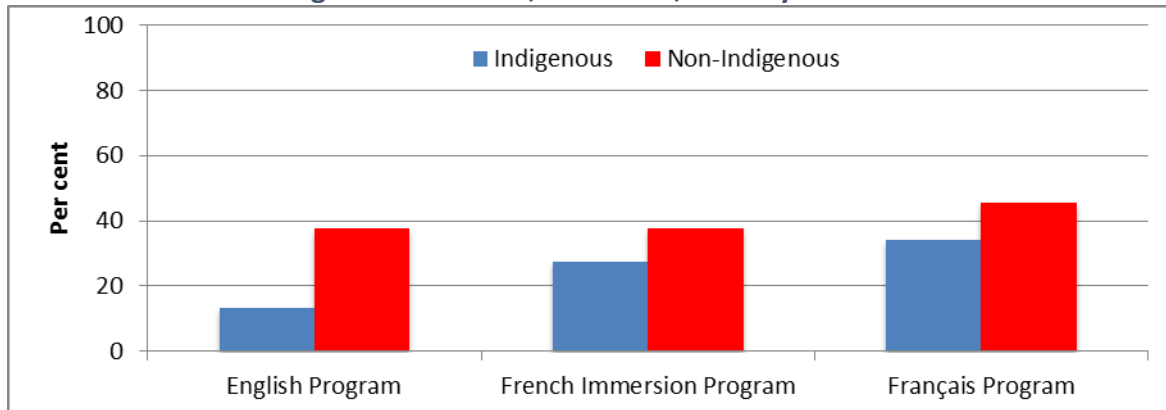
<sup>i</sup> Manitoba Education and Training. Middle Years Assessment: Grade 7 Mathematics: support document for teachers. <http://www.edu.gov.mb.ca/k12/assess/support/math7/index.html>

**Competency 1: Number Sense.** The number sense competencies being assessed include comparing and ordering fractions, decimals, and numbers expressed in different ways. Students need to develop mental images to represent numbers in order to facilitate their comparison. As students acquire new number concepts, they need to make sense of the numbers by becoming aware of the relationships found in numbers and the structure of the number system. Students need to develop an understanding of different ways in which numbers are expressed; they also need to be able to compare their value relative to one another.

**Competency 2: Number Skills.** Students need to observe patterns, speculate about them, discuss these speculations, and make generalizations. Through patterns, students discover relationships and develop understandings about mathematics. The knowledge and understanding of patterns and relations prepare students to understand and work with algebra and functions in the Senior Years. Today's math learners also continue to need mental math skills. Being able to obtain exact answers for numerically simple problems and arithmetic tasks without using paper and pencil, or technology remains a necessary skill for students.

In 2017, Indigenous students were less likely to meet the mid-grade performance expectations in all five competencies compared to non-Indigenous students in all three programs (Figure 5.116).

**Figure 5.116 Per cent of Grade 7 students meeting mid-grade performance expectations in all five competencies in the Middle Years Assessment in Mathematics (English Program, French Immersion Program and Français Program), Indigenous and non-Indigenous students, Manitoba, January 2017**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/) Retrieved July 24, 2017

In the French Immersion Program and the Français Program, the percentage of Indigenous students meeting the mid-grade performance increased between 2008 and 2017. The percentage remained stable in the English Program.

### Reading

**Grade 3 reading:** Early in the school year, teachers assess Grade 3 students in reading competencies. 2009/10 was the first year of province-wide assessment in Grade 3. A recent report measured Grade 3 reading using three reading competencies.<sup>j</sup> For each reading competency, students were categorized according to one of four levels of achievement for Grade 3 entry level performance standards: 1) meeting expectations, 2) approaching expectations, 3) needs ongoing help, and 4) out of range.<sup>k</sup>

In Fall 2016, 47% of Grade 3 students in Manitoba met reading expectations for competencies in the Grade 3 Assessment in Reading in the English Program (reading in English). This was the

<sup>j</sup> Manitoba Education and Training Cataloguing in Publication Data, Grade 3 assessment in reading: support document for teachers. [http://www.edu.gov.mb.ca/k12/assess/docs/gr3\\_reading/index.html](http://www.edu.gov.mb.ca/k12/assess/docs/gr3_reading/index.html)

**Competency 1: Student reflects on and sets reading goals.** Together teachers and students develop three to five criteria to reflect essential learning.

**Competency 2: Student uses strategies during reading to make sense of texts.** As readers interact with text, they use three language cueing systems as sources of information: semantic, syntactic, and graphophonic systems. Semantic cues deal with the overall meaning of the text as well as with the meaning of specific words. Syntactic cues involve the patterns or structures of word order in sentences, clauses, and phrases, and their corresponding punctuation. Graphophonic cues involve written letters and their corresponding spoken sounds.

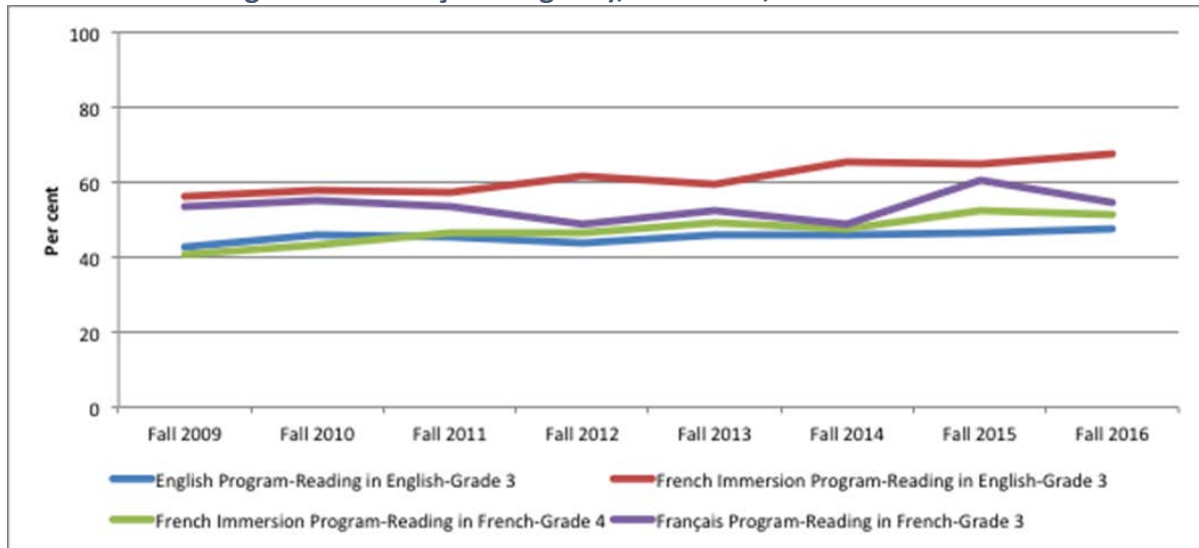
**Competency 3: Student demonstrates comprehension.** Proficient readers are able to apply a wide range of strategies flexibly as they construct meaning and develop creative and critical thinking skills.

<sup>k</sup> Used to describe those students who are working well below grade-level curriculum relative to the competencies assessed due to their learning disabilities or their need for new language learning.

case for 68% in the French Immersion Program (reading in English), 51% French Immersion Program (reading in French) and 54% in the Français Program (reading in French).

From 2009 to 2016, the percentage meeting the expectations increased from 43% to 47% in the English Program, from 56% to 68% in the French Immersion Program (reading in English), from 41% in 51% in the French Immersion Program (reading in French-Grade 4), and stayed relatively stable, with some variation, in the Français Program (reading in French) (Figure 5.117).

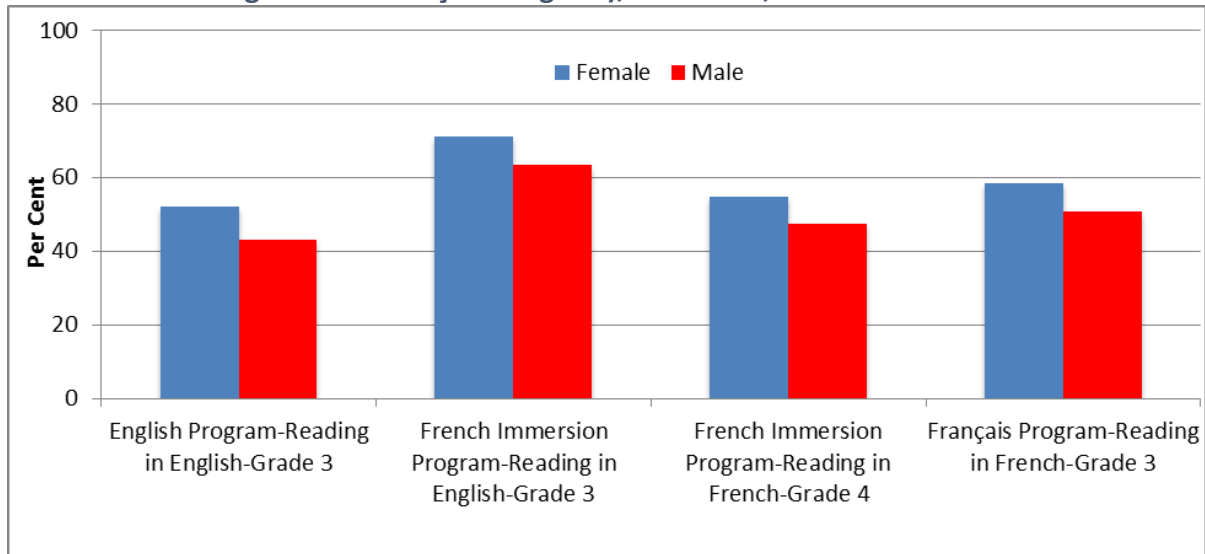
**Figure 5.117 Per cent of students meeting expectations in all three competencies in the Grade 3/4 Assessments in Reading (English Program, French Immersion Program and Français Program), Manitoba, Fall 2009 to Fall 2016**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/) Retrieved July 24, 2017

In 2016, the percentage of girls meeting expectations in all three competencies in reading was higher than that of boys in all of the programs (Figure 5.118).

**Figure 5.118** Per cent of students meeting expectations in all three competencies in the Grade 3/4 Assessments in Reading (English Program, French Immersion Program and Français Program), Manitoba, Fall 2016



Source: Manitoba Government Department of Education. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/) Retrieved July 24, 2017

The percentage of non-Indigenous students meeting expectations in the all three competencies was higher than that of Indigenous students in all of the programs.

**Grade 8 Reading:** In January of each year since 2008, teachers in Manitoba assess the reading comprehension and expository writing skills of Grade 8 students.<sup>1</sup> The information below indicates the percentage of students who meet mid-grade performance in all three sub-competencies in reading comprehension and, separately, for expository writing.

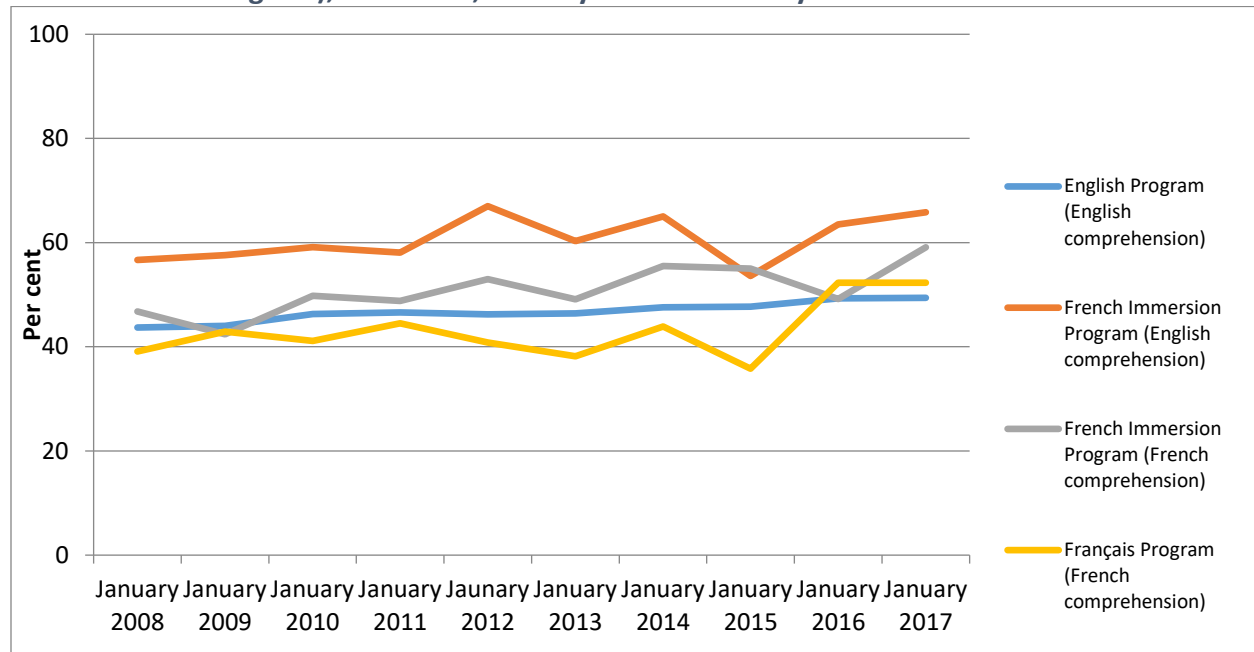
The percentage of Grade 8 students meeting mid-grade performance on all three sub-competencies in the Middle Years Assessment in Reading Comprehension increased from 2008 to 2017 in all programs. The biggest increase was seen in the Français Program (reading in French comprehension), from 39% in 2008 to 52% in 2016 (Figure 5.119).

<sup>1</sup> Manitoba Education and Training. Middle Years Assessment: Grade 8 English Language Arts: Reading Comprehension and Expository Writing: support document for teachers. <http://www.edu.gov.mb.ca/k12/assess/support/ela8/index.html>

**Competency 1: Reading Comprehension.** Student comprehends a variety of grade-level texts (fiction and non-fiction).

**Competency 2: Expository Writing.** Student writes expository texts for a variety of audiences and purposes (to inform, describe, explain, persuade, state and opinion, etc.).

**Figure 5.119 Per cent of Grade 8 students meeting mid-grade performance expectations in all three competencies in the Middle Years Assessment in Reading Comprehension (English Program, French Immersion Program and Français Program), Manitoba, January 2008 to January 2017**



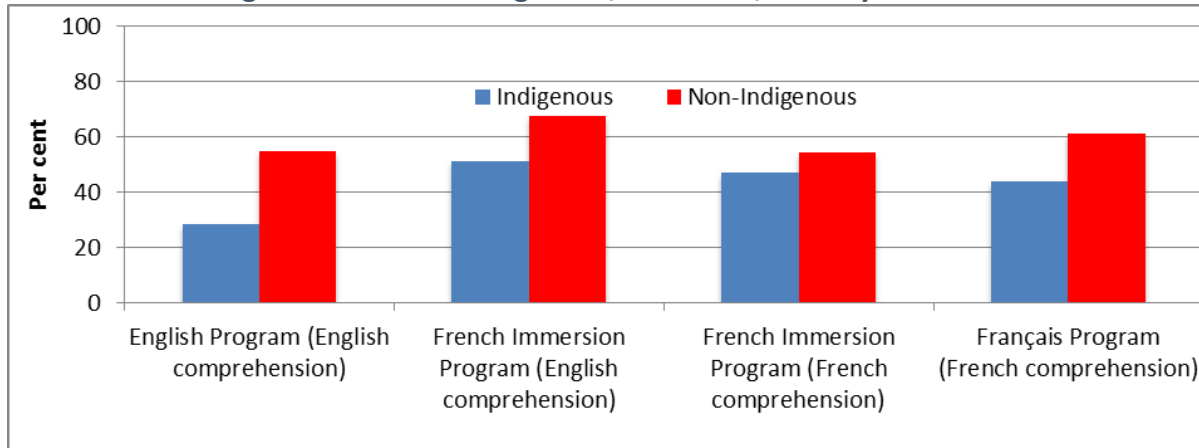
Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/) Retrieved July 24, 2017

Girls were 1.4 times more likely to meet mid-grade performance expectations in all three sub-competencies in reading comprehension than boys in all four program areas: English (reading comprehension in English), French immersion (reading comprehension in English and in French) and Français (reading comprehension in French).<sup>207</sup>

In 2017, non-Indigenous students were more likely than Indigenous students to meet mid-grade performance expectations in all three sub-competencies in reading comprehension. In the English Program (English comprehension), non-Indigenous students were 1.9 times more likely to meet mid-grade performance in all three sub-competencies than were Indigenous students (Figure 5.120).

**Figure 5.120 Per cent of Grade 8 students meeting mid-grade performance in all three sub-competencies in the Middle Years Assessment in Reading Comprehension**

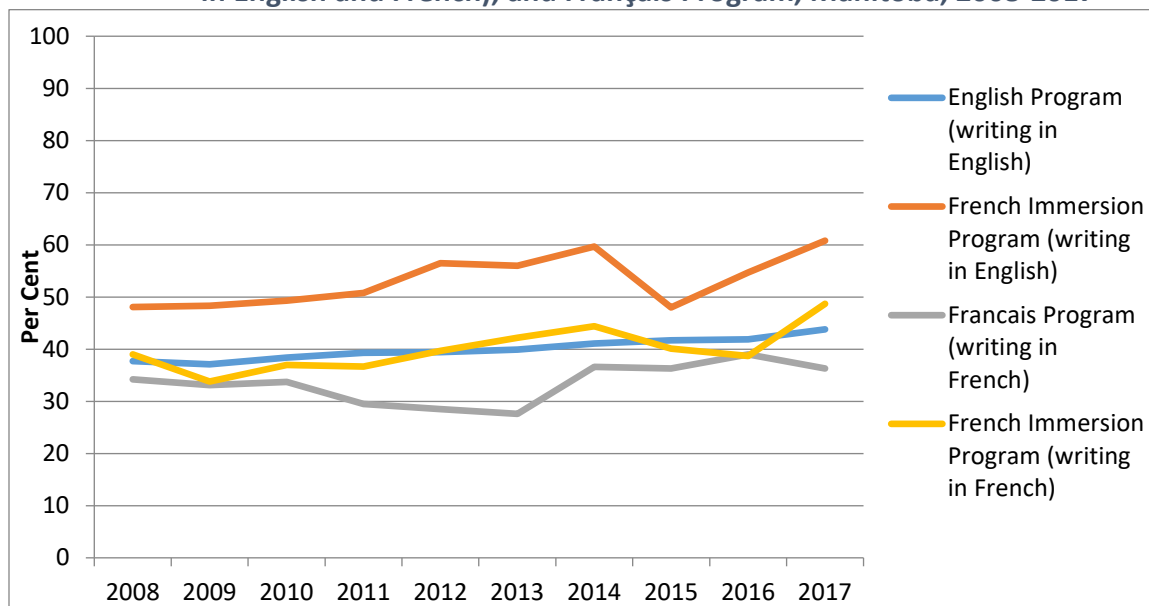
**(English Program, French Immersion Program and Français Program)  
Indigenous and non-Indigenous, Manitoba, January 2017**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/) Retrieved July 24, 2017

In 2017, 44% of Grade 8 students in the English Program met the mid-grade performance expectations in expository writing in English. A higher proportion, 61% of Grade 8 students in the French Immersion Program met the mid-grade performance expectations in expository writing in English. A lower proportion, 36% of Grade 8 students in the Français Program met the mid-grade performance expectations in expository writing in French. Of Grade 8 students in the French Immersion Program, 49% met the mid-grade expectation in expository writing in French (Figure 5.121). Female students were more likely to meet the expectations than were male students in all four programs and both languages.

**Figure 5.121 Per cent of Grade 8 students meeting mid-grade performance expectations in Expository Writing in the English Program, French Immersion Program (writing in English and French), and Français Program, Manitoba, 2008-2017**

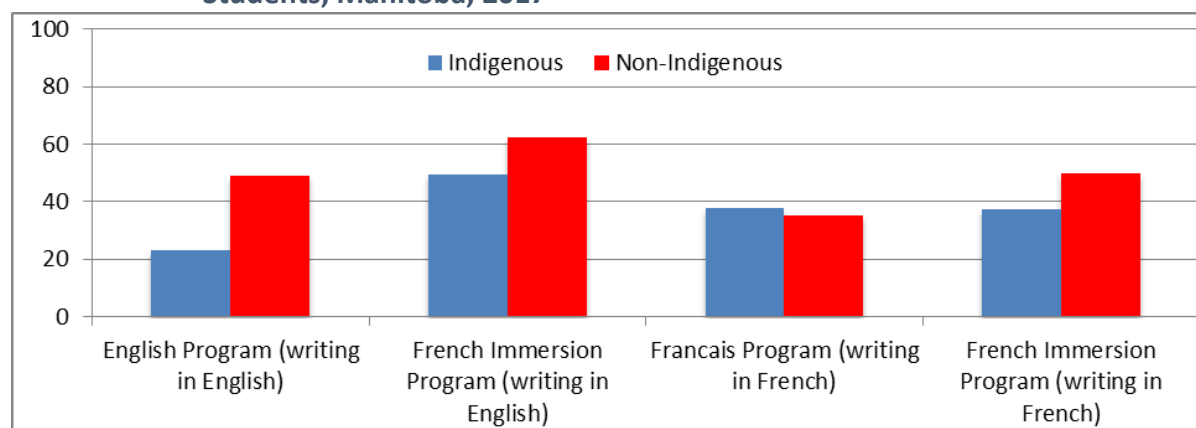


Source: Government of Manitoba Department of Education. [http://www.edu.gov.mb.ca/k12/grad\\_rates/index.html#proxy](http://www.edu.gov.mb.ca/k12/grad_rates/index.html#proxy).

Notes: English Program (writing in English), French Immersion Program (writing in English), Français Program (writing in French), and French Immersion Program (writing in French)

In 2017, 23% of Indigenous students in the English Program met the mid-grade performance expectations with regards to expository writing in English as did 49% of non-Indigenous students; 49% of Indigenous students in the French Immersion Program met the mid-grade performance expectations expository writing in English as did 62% of non-Indigenous students; 38% of Indigenous students in the Français Program met the mid-grade performance expectations with regard to expository writing in French as did 35% of non-Indigenous students; 37% of Indigenous students in the French Immersion Program met the mid-grade performance expectations with regard to expository writing in French as did 50% of non-Indigenous students (Figure 5.122).

**Figure 5.122 Per cent of Grade 8 students meeting mid-grade performance expectations in Expository Writing, English Program, French Immersion Program (writing in English and French), and Français Program, Indigenous and non-Indigenous Students, Manitoba, 2017**



Source: Government of Manitoba Department of Education. [http://www.edu.gov.mb.ca/k12/grad\\_rates/index.html#proxy](http://www.edu.gov.mb.ca/k12/grad_rates/index.html#proxy).

Notes: English Program (writing in English), French Immersion Program (writing in English), Français Program (writing in French), and French Immersion Program (writing in French)

### 5.4.3 Learning Gaps and Summer Learning Loss

Building a successful educational environment requires a great deal of support for children in both school and home environments. Parents play an important role in helping children achieve in academics. Research shows having a supportive home learning environment has strong effects on children’s educational achievement.<sup>208</sup>

A significant amount of learning takes place outside of school. In fact, children spend most of their time outside of school, but the quality of their non-school environments varies considerably. Research comparing the school season with the non-school (summer) season has shown that socioeconomic and racial/ethnic gaps in academic skills such as reading and math grow primarily during the summer. This suggests that non-school factors, such as family, neighbourhood, and community, play an important role in learning and in educational outcomes, while school offsets some of these inequalities.<sup>209</sup> A US study found that differential summer learning over the elementary school years accounts for much of the income-related differences in high school tracking (university preparation or not), high school completion, and four-year college attendance.<sup>210</sup> Encouraging parents and families to become involved in their child’s school and to support their child’s learning, both at home and at school, is important.

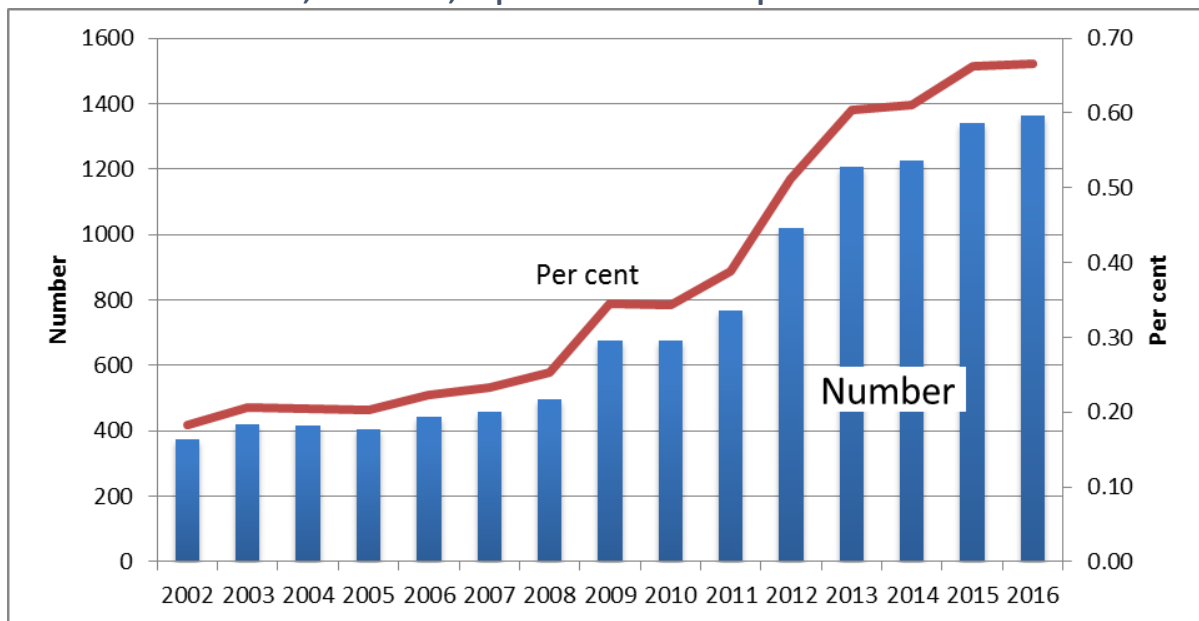


### 5.4.3.1 Homeschooling

In Manitoba, parents and guardians may choose to homeschool their children. Parents and guardians are responsible for their child's education, as their child does not attend school: They are responsible for obtaining resources and materials for the program of study. The Homeschooling Office within the Independent Education Unit of Manitoba Education and Training administers homeschools and supports homeschooling families throughout the province.<sup>211</sup>

In 2016/17, there were 1,365 students in Kindergarten to Grade 6 who were homeschooled. They accounted for 0.67% of all students enrolled in school. The number of students homeschooled was up 3.7-fold from 373 in 2002/03. The percentage of all students homeschooled was up from 0.18% in 2002/03 (Figure 5.123). According to a national study, this is a trend that is also occurring in British Columbia, Ontario, Québec, and Alberta.<sup>212</sup>

**Figure 5.123** Number and per cent of students who are homeschooled, Kindergarten to Grade 6, Manitoba, September 2002 to September 2016



Source: Manitoba Education and Training, Provincial School Enrolment Annual Reports.  
[http://www.edu.gov.mb.ca/k12/finance/sch\\_enrol/enrolment\\_2016.pdf](http://www.edu.gov.mb.ca/k12/finance/sch_enrol/enrolment_2016.pdf) (Accessed October 14, 2017).

**Individualized Education Plans (IEP):** An IEP is a written document developed and implemented by a team, outlining a plan to address the individual learning needs of students. Individual education planning is an established part of educational practice in Manitoba as a way to help all students reach their individual learning potential.<sup>213</sup>

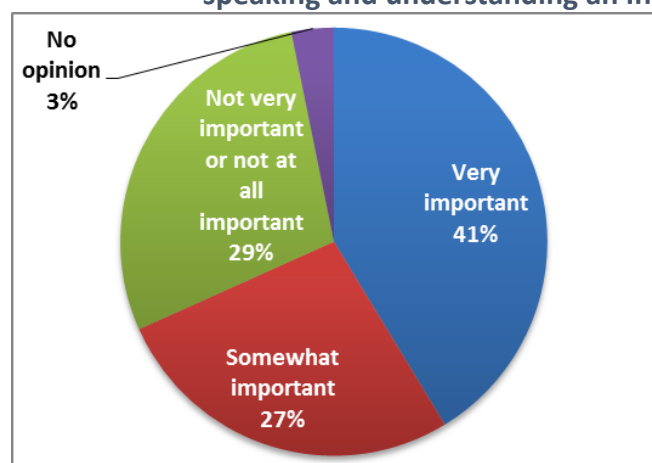
### 5.4.4 Cultural and Other Learning

Learning has many dimensions. In addition to academic learning, social and cultural learning serve as major contributors to child development.<sup>214</sup> Understanding our parents' and families' cultures is an important part of the learning process and contributes to children's sense of identity and self-concept. Further, in a multicultural country such as Canada, gaining cultural knowledge also helps children understand and appreciate the diverse backgrounds of their peers, neighbours and community members.

Cultural learning may also have important effects on the health of communities. A study of British Columbian First Nations communities found that knowledge of an Aboriginal language was a significant predictor of community health, especially among youth.<sup>199</sup> Cultural learning is thus an important tool for promoting healthy future generations in Manitoba.

According to the Aboriginal Peoples Survey, in 2012, 41% of First Nations children and youth aged 6 to 14 (not on reserve) thought it was very important to speak or understand an Indigenous language, 29% thought it was somewhat important, and 29% thought it was not very important (Figure 5.124).

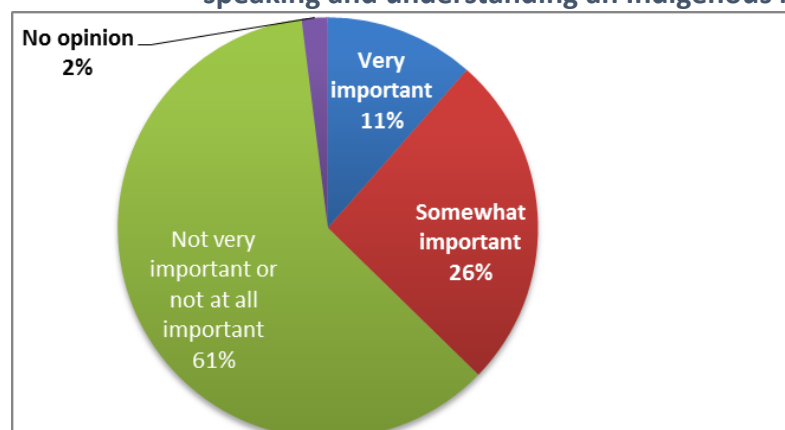
**Figure 5.124** Distribution of First Nations children and youth ages 6 to 14 by importance of speaking and understanding an Indigenous language, Manitoba, 2012



Source: Statistics Canada. Table 105-0512 - Health indicator profile, by Aboriginal identity, age group and sex, four-year estimates, Canada, provinces and territories, occasional (rate) (Accessed September 27, 2017). <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050512&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=>  
 Note: Does not include First Nations children living on reserve.

According to the Aboriginal Peoples Survey, in 2012, 12% of Métis children and youth ages 6 to 14 thought it was very important to speak or understand an Indigenous language, 29% thought it was somewhat important, and 61% thought it was not very important (Figure 5.125).

**Figure 5.125** Distribution of Métis children and youth aged 6 to 14 by importance of speaking and understanding an Indigenous language, Manitoba, 2012



Source: Statistics Canada. Table 105-0512 - Health indicator profile, by Aboriginal identity, age group and sex, four-year estimates, Canada, provinces and territories, occasional (rate) (Accessed September 27, 2017). <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050512&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=>

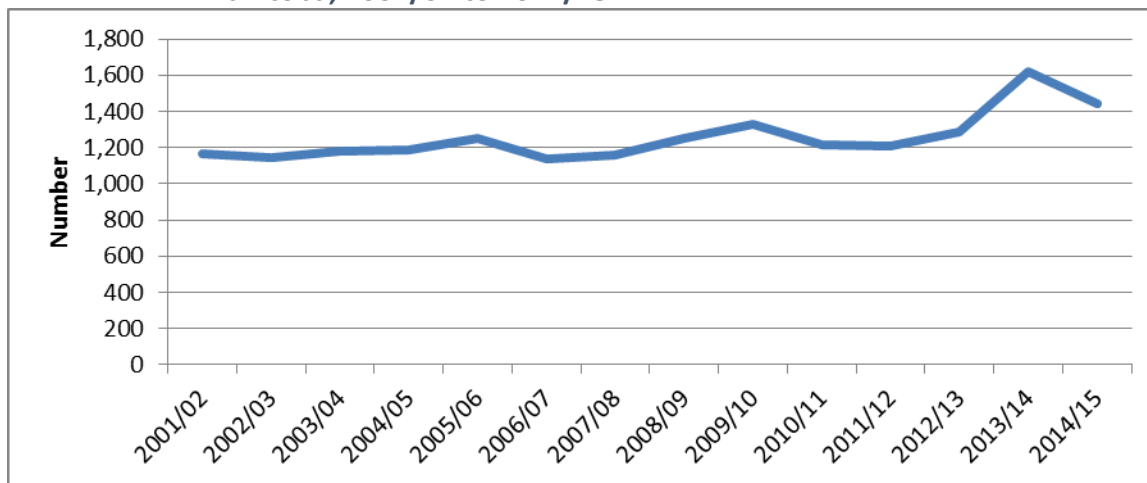
In Manitoba, Indigenous cultures and histories are taught mainly through the Social Studies curricula from K to 12 (mandatory at K to 11). Indigenous-related learning outcomes have been included for all students at each grade and are intended to help students develop knowledge and understanding of Indigenous culture and history. In addition, Indigenous student-specific learning outcomes are included in order to enhance the development of language, identity, culture and community for Indigenous learners.

Treaty Education and Residential Schools education are part of the mandatory Social Studies curricula, with Residential Schools a focus in Grades 9 and 11 and Treaty Education a focus in Grades 5 and 6 in particular. Manitoba is working with partners to improve this education

Other curricula, including science, English language arts and Kindergarten include Indigenous perspectives and opportunities to study Indigenous cultures, history and ways of knowing as an “integratable” area that is on a priority level similar to Education for Sustainable Development and Information and Communications Technology.<sup>215</sup>

From 2001/02 to 2014/14, the number of Manitoba students who are enrolled in public school Indigenous language programs increased by 23% from 1,167 to 1,440 (Figure 5.126).

**Figure 5.126** Number of students enrolled in public school Indigenous language programs, Manitoba, 2001/02 to 2014/15



Source: Statistics Canada. Table 477-0039 Headcount enrolments in public school Aboriginal language programs, Canada, provinces and territories. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=4770039&p2=33> Accessed July 24, 2017  
Includes Indigenous language as a subject, as well as programs where all instruction is taught in an Indigenous language.

## 5.5 Socially Engaged and Responsible

### 5.5.1 Socially Engaged

In middle childhood, social competencies include the ability to get along with others, as well as handling increased roles within the family, peer group, and broader community. Social engagement may be reflected in school attachment, engagement in learning, and participation in the community.

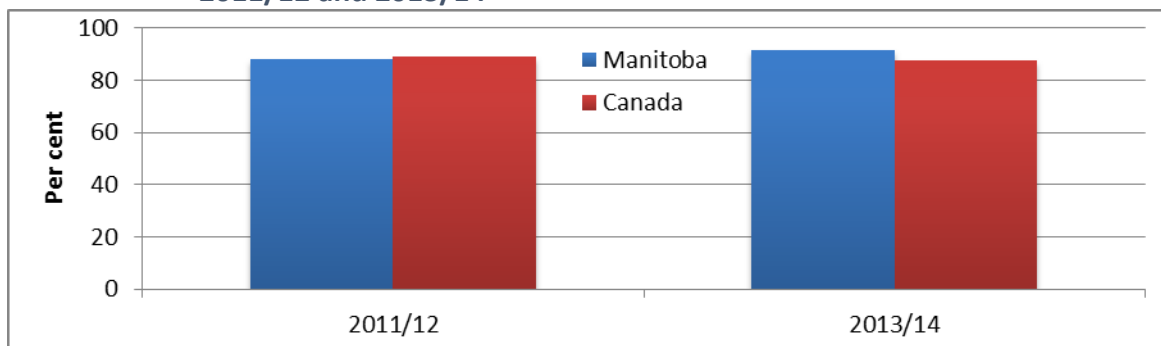
Access to recreation, leisure, arts, and culture also allows children to socially engage. Organized activities where children can learn and practice their social skills are an important part of developing social competence.<sup>216</sup> Participating in organized or unorganized sports, joining clubs

or groups, and taking music, dance or art lessons are examples of ways in which young people can participate in their community, learn valuable new skills, and socialize outside of their families. Children’s involvement in cultural and recreational activities helps them to be physically, emotionally, and socially healthy. These activities can improve leadership skills, self-confidence, and social skills such as sharing and cooperation. They also provide children with an opportunity to learn from coaches, instructors and mentors. Unfortunately, the extent to which children participate in leisure, arts, and recreation activities depends on their family’s economic resources and on the availability of facilities and programs in their community. The high cost of equipment or supplies, instruction, and facility fees that are often required to participate in many activities, acts as a strong deterrent for lower-income families.<sup>217</sup>

Participation in the neighbourhood and wider community is another way that school-age children socially engage. Community engagement and participation have been linked with positive behaviour, a higher sense of confidence and self-worth, and an increased likelihood of seeking out positive challenges.<sup>218,219</sup>

Over time, from 2011/12 to 2013/14, in response to the question, “How would you describe your sense of belonging to your local community?”, Manitoba youth (ages 12 to 14 years) reported an increasingly stronger sense of belonging, compared to Canadian 12 to 14 year olds (Figure 5.127).

**Figure 5.127 Per cent of 12- to 14-year-olds who state that their sense of belonging to their local community is somewhat strong or very strong, Manitoba and Canada, 2011/12 and 2013/14**



Source: Canadian Community Health Survey 2011-2012 & 2013-2014, Public Use Data Set, Accessed through ODESI.

## 5.5.2 Socially Responsible

As children grow older, they are expected to be socially responsible, adhering to norms set out by their families, schools, and broader society. Moral reasoning (the ability to make our own judgments about right and wrong) develops during middle childhood,<sup>58</sup> along with self-regulation and prosocial behaviour.

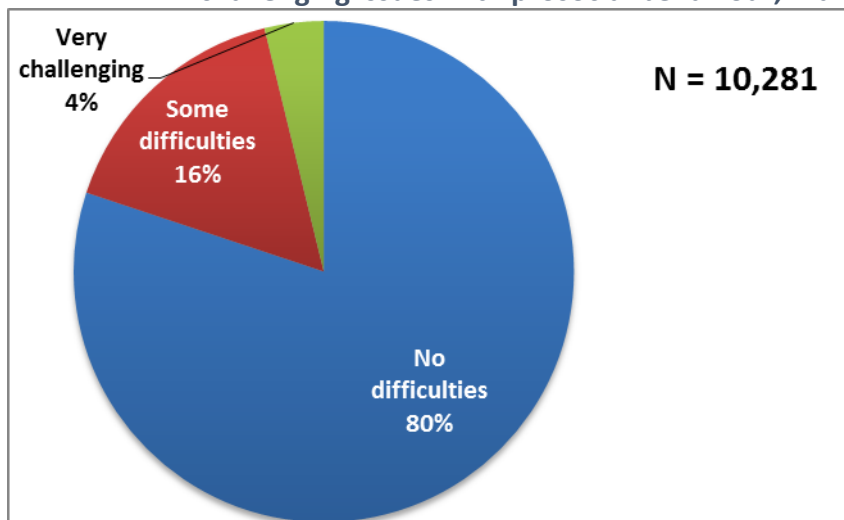
### 5.5.2.1 Prosocial behaviour

Positive social skills, including the ability to express oneself and to get along with others, are associated with higher self-esteem in school-aged children. Children who lack adequate or age-appropriate social skills may have fewer friends; feel isolated, anxious, or distressed; and struggle in school and social settings.<sup>220</sup>

Prosocial refers to behaviours that promote positive social interactions, including showing sympathy to someone who has made a mistake; trying to help or comfort someone who is hurt, sick, or upset; or volunteering to help clean up someone else’s mess. Prosocial behaviour is an important indicator of the ability to successfully participate in the social environment.

According to Manitoba’s Grade 5 Mental Health Survey, 80% of students self-report no problems with prosocial behaviour, while 16% have some difficulty and 4% have very challenging issues with prosocial behaviour. In this survey, prosocial behaviour includes attributes such as being considerate of other people’s feelings, sharing readily with other youth, helping if someone is hurt or upset, being kind to younger children, and offering to help others often (Figure 5.128).

**Figure 5.128** Per cent of Grade 5 students who have no difficulties, some difficulties or very challenging issues with prosocial behaviour, Manitoba, 2015/16



Source: Healthy Child Manitoba Office. Manitoba Grade 5 Mental Health Survey Report. 2015/16. Student-completed data

### 5.5.2.2 Antisocial behaviour

The link between adverse childhood experiences and involvement in antisocial behaviour is firmly established. Numerous studies have shown that children and youth who are the most disadvantaged and vulnerable are the most likely to come into contact with the criminal justice system.<sup>221</sup> It is important to note that only a relatively small group of children persistently engage in antisocial behaviour: more than half of children who show early signs of antisocial behaviour do not persist in it.<sup>59</sup>

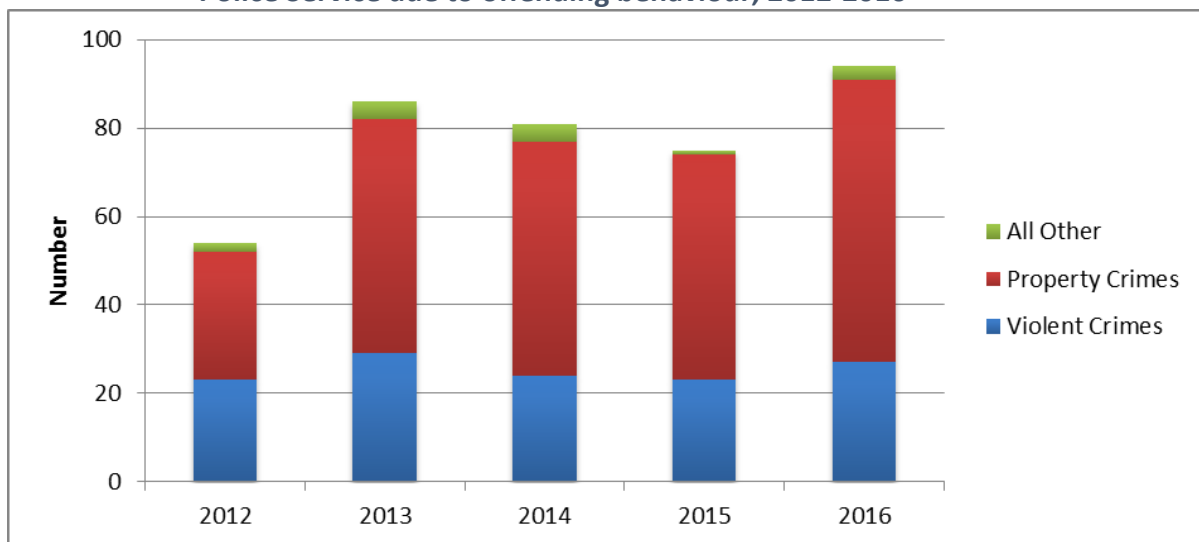
Because children under age 12 are under the age of legal criminal responsibility, no data are available on gang involvement or criminal activity for middle childhood school-age children in Manitoba. The only data available are from the Turnabout Program, a voluntary provincial prevention program for children under 12 years of age who are 1) behaving in ways that would result in criminal charges if they were 12 or older and 2) identified as at risk of coming into contact with the law. Referrals to Turnabout are made by law enforcement, community agencies, schools, child and family service agencies, community members and concerned parents. The program connects at-risk children and their families with appropriate community resources that will support the family and ‘turn around’ the child’s behaviour. On average, 200

referrals are made each year. The most common incidents are fire setting, mischief, and shoplifting. These numbers and types of incidents should not be seen as representative of antisocial type behaviour among children under age 12, as the program is based on referrals and participation is voluntary.

### 5.5.2.3 Children and youth involved with the justice system

In 2016, 94 children under age 12 had contact with the Winnipeg Police Service due to offending behaviour. That number has fluctuated over the last five years, but 2016 was the highest. Of the total, 29% were due to violent crimes and 68% due to property crimes (Figure 5.129).

**Figure 5.129 Number of children under 12 years who have had contact with the Winnipeg Police Service due to offending behaviour, 2012-2016**



Data Source: Winnipeg Police Service  
 Note: data for 2016 does not include December

### 5.5.2.4 Engaged in school

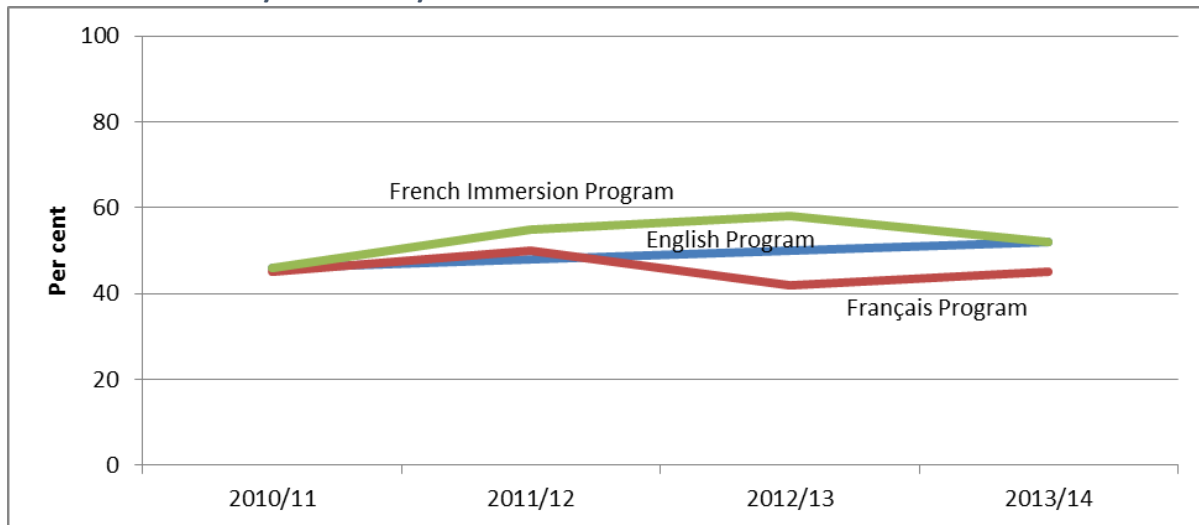
School attachment refers to the sense of belonging and support children feel from their school. Children who feel connected to their school tend to do better academically, have higher self-esteem, and are more likely to enjoy school and continue with their education.<sup>222</sup> Engagement in school is also important for a sense of belonging and contributes to good mental health.<sup>223</sup> When children are engaged in their learning, they tend to learn more and be more willing to increase their knowledge. Positive and supportive school environments encourage children to explore, test their abilities, enhance their skills and experience success. Parental involvement, quality mentoring programs, and academic supports all help support engagement in learning.<sup>224</sup>

Four criteria are used by Manitoba teachers to assess Grade 7 students' competencies related to engagement in school. If the student is 'established' it means that they nearly always demonstrates the described behaviour.

In 2013/14, 52% of Grade 7 students in the English Program had established competence when it came to demonstrating an interest in learning, up from 46% in 2010/11. In the Français

Program, it was 45%, relatively stable since 2010/11. In the French Immersion Program, it was 52%, up from 46% in 2010/11, but down from 58% in 2012/13 (Figure 5.130).

**Figure 5.130 Per cent of Grade 7 students with established competency in demonstrating an interest in learning in the Student Engagement Assessment, English Program, French Immersion Program and Français Program, Manitoba, 2010/11 to 2013/14**

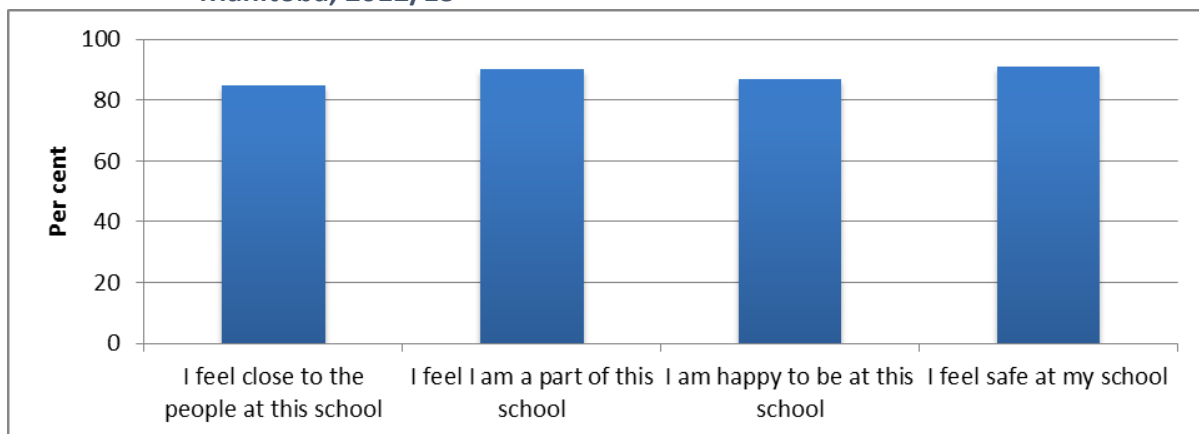


Source: A Profile of Student Learning and Performance in Manitoba, 2010-2014  
<https://www.edu.gov.mb.ca/k12/docs/reports/profile/profile14.pdf> Accessed July 24, 2017

#### 5.5.2.5 Belonging to the school community

According to the 2012/13 Manitoba Youth Health Survey, the majority of Manitoba students in Grades 7 and 8 feel that they belong and are safe at school: 91% felt that they were safe at their school, 90% felt they were a part of the school, 87% were happy to be at the school, and 85% said they felt close to the people at their school (Figure 5.131).

**Figure 5.131 Per cent of Grades 7 and 8 students who feel engaged and safe at school, Manitoba, 2012/13**

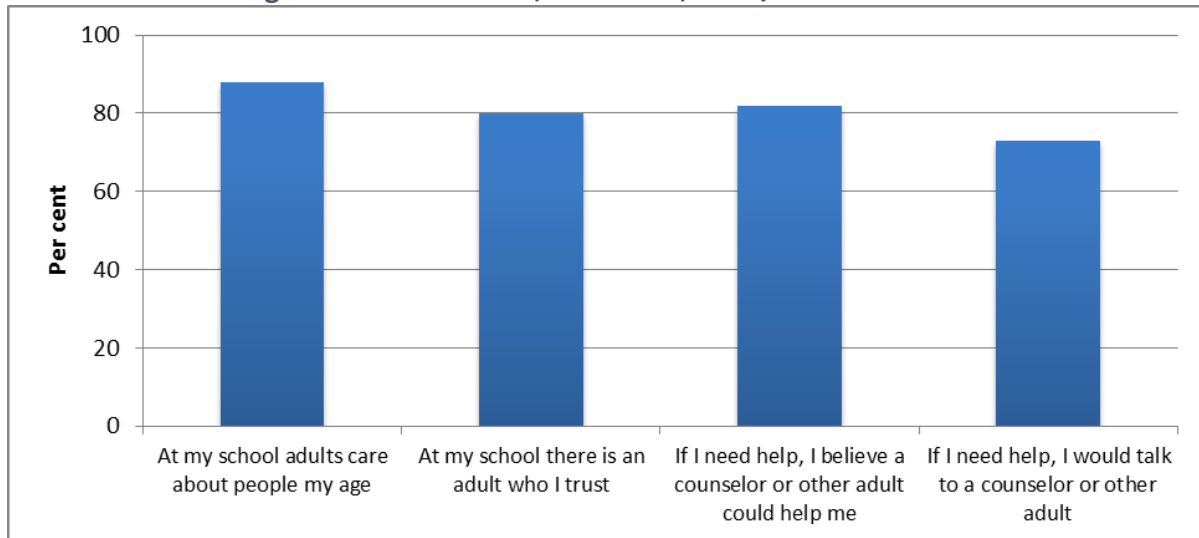


Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

For the most part, the majority of Manitoba students in Grades 7 and 8 also feel that the adults in their school care about them and can be trusted: 88% felt that the adults at their school care

about people their age; 82% felt that if they needed help, the adults at their school would help them; and 80% felt there was an adult at their school they could trust. Fewer, but still a majority, 73%, would talk to a counsellor or other adult if they needed help (Figure 5.132).

**Figure 5.132 Per cent of Grades 7 and 8 students who feel the adults at their school are caring and can be trusted, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

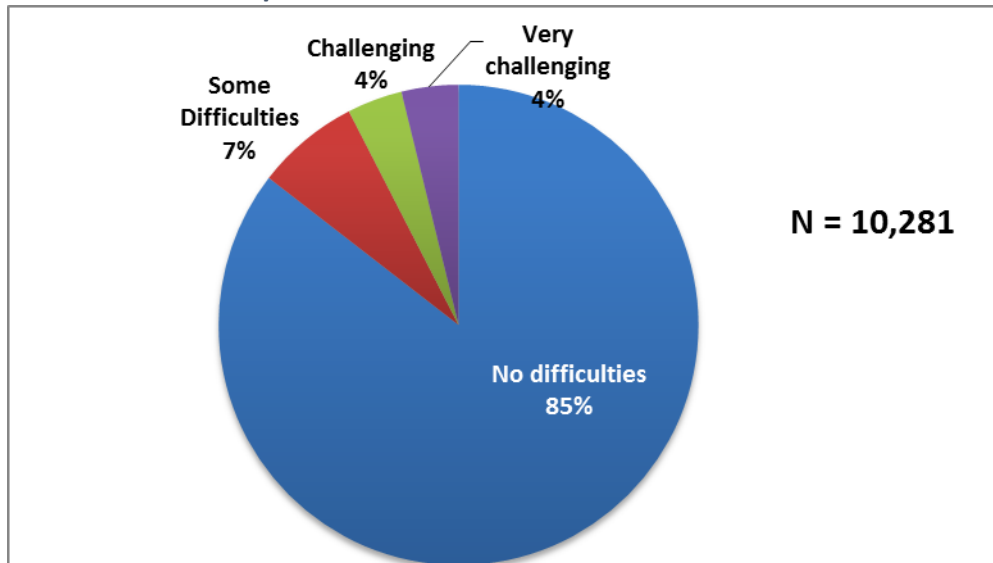
#### 5.5.2.6 Peer engagement

Peers and peer relationships become increasingly important to young people through middle childhood. Engaging with peers can motivate young people to be more engaged in the classroom and in school work as well as extracurricular activities.<sup>225,226</sup>

According to Manitoba's Grade 5 Mental Health Survey, 85% of students self-report no problems with peer relationships, while 7% have some difficulties; 4% find relationships with peers challenging; and 4% find them very challenging. In this survey, peer relationships are assessed on a number of factors, including the desire to be with other young people, having at least one good friend, generally being liked by other youth, not being picked on by with other youth, and getting along better with other youth than adults (Figure 5.133).



**Figure 5.133** Per cent of Grade 5 students who have no difficulties, some difficulties, challenging or very challenging issues with peer relationships, Manitoba, 2015/16



Source: Healthy Child Manitoba Office. Manitoba Grade 5 Mental Health Survey Report. 2015/16. Student-completed data

## 5.6 Summary

Middle childhood is a period in which significant developmental milestones are achieved. For children ages 6 to 14, developmental tasks and stages include increasing physical, emotional, learning, and social abilities and capacities. Physically, children continue to develop rapidly, Children’s brains are also developing in middle childhood. With these changes comes the ability to engage with and explore the world in new and more sophisticated ways. Puberty begins toward the end of the middle years, from around 11 to 14.

- Asthma remains the most common chronic disease in middle childhood and appears to be increasing over time. It is 2 to 3 times more prevalent for First Nations and Métis children.
  - In 2013/14, the asthma rates were 9% for boys and 11% for girls in Manitoba, compared to 13% for boys and 9% for girls in Canada.
- The prevalence of attention deficit hyperactivity disorder (ADHD) is increasing over time, as is Autism Spectrum Disorder (ASD).
  - For ages 6 to 12, the prevalence of ADHD was 7.5% in 2005/06-2008/09 and 8.7% in 2009/10-2012/13.
  - For ages 6-12, the lifetime diagnostic prevalence of ASD was 1.2% in 2005-/06-2008/09 and 1.5% in 2009/10-2012/13.
- Diagnosing Fetal Alcohol Spectrum Disorder (FASD) has great benefits for children at any stage in their development. Commonly used parenting and education techniques may not work for children with FASD and can result in frustration for both the child and the adult. By having clear information about the disability, parents, teachers, and other professionals can provide appropriate interventions and advocate for effective supports for the child. Shifting from the perspective of “trying harder” to “trying differently” can help parents and those working with children living with FASD look for ways to assist children to successfully learn, grow and adapt. (<http://fasdmanitoba.com/assessment>).

- Approximately two-thirds of Manitoba 7-year-olds have had all of the recommended immunizations. The Northern Health Regions had the highest rate at 74%.
- Two-thirds of Manitoba Grade 7 and 8 students have healthy weights. Other data indicate overweight and obesity have risen over time to 26% for Manitoba children (ages 12-19), higher than Canada.
  - Only half of Manitoba Grade 7 and 8 students are active for the recommended 60 minutes per day, with one in six being inactive daily.
  - 15% of Grade 7 and 8 students are inactive.
- Less than 40% of Grade 7 and 8 students get the recommended 9 hours of sleep each school night.
- Many students spend 3 or more hours of screen time each weekday (40%) and on weekends (60%).
- Less than half of Grade 7 and 8 students get the recommended amount of fruits and vegetables daily.
- Over one-third of Grade 7 and 8 children are at risk for future mental health problems. Further, 31% of boys and 43% of girls reported that they had felt so sad or hopeless in the past year that they stopped doing their usual activities for a while.
  - Diagnosed anxiety and mood disorders, and conduct disorder, (ages 6-12 years) appear to be on the rise, particularly in lower-income communities.
    - The four-year diagnosed prevalence of mood and anxiety disorders among 6- to 12-year-olds was 1.8% in 2005/06-2008/09 and 2.2% in 2009/10-2012/13.
    - The four-year diagnostic prevalence of conduct disorders among 6- to 12-year-olds was 1.9% in 2005/06-2008/09 and 2.1% in 2009/10-2012/13.
  - One in five Grade 5 children report at least one mental health difficulty.
- Unintentional injury hospitalizations in middle childhood appear to be declining over time, with falls as the leading cause (similar to early childhood).
  - The rate of injury hospitalization among children aged 5-9 was 1.4 per 1,000 population in 2015/16.
  - Motor vehicle collisions continue to be the leading cause of death due to unintentional injury.
- Police-reported family violence among children and youth (ages 0-17 years) is higher in Manitoba, than in Canada. The rate is higher among girls than it is among boys.
  - In 2015, the rate of police-reported family violence among children and youth 0 to 17 years of age was 374 per 100,000 in Manitoba.
- Up to a third of Grade 4-6 students report being bullied (verbal, social, physical, cyber). The rate is similar for Grade 7-8 students (ridicule, body shaming, physical threat or injury, racism).
- Children's (under age 12) exposure to household second-hand smoke has dropped over the past decade.
- Almost half (42%) of all children and youth ages 0 to 18 years who are living in social housing are 6-12 years.
  - More Manitoba children under age 15 live in core housing need (16%), compared to Canada (14%). Children in lone-parent families are 4 times more likely to live in core housing need compared to children living in couple families.
- Food insecurity for children ages 6-17 appears to be declining in Manitoba but is still higher than Canada.

- In middle childhood (ages 6-14), more First Nations and Métis children in Manitoba live in households that have low or very low food security, compared to Canada.
- In Manitoba in 2011/12, 10% of children ages 6-17 lived in households that had moderate or severe food insecurity.
- Manitoba 2012: 26% of First Nation households with children ages 6-14 had low or very low food security, as did 20% of Métis households with children ages 6-14.
- Performance in middle years academic assessments have increased for the most part among Manitoba students.
  - However, less than half of students meet expectations in all areas of Grade 3 numeracy and Grade 7 mathematics, and as low as one in six Indigenous students meet these expectations.
  - Between roughly 40-60% of students meet expectations in all areas of Grade 3 reading and Grade 8 reading comprehension, and as low as one in six Indigenous students meet these expectations.
- The number of children who are homeschooled in Manitoba has almost quadrupled (3.7x) since 2002.
- In Manitoba, 70% of First Nations children and 40% of Métis children (ages 6-14) thought it was somewhat or very important to speak an Indigenous language.
  - The number of Manitoba students enrolled in public school Indigenous language programs increased by 23% between 2001/02 and 2014/15.
- Most 12- to 14-year-olds in Manitoba feel a sense of belonging to their local communities.
- Most (80%) of Manitoba's Grade 5 students are prosocial (e.g., considerate of others' feelings, share, help, are kind to others).
- Between 40%-60% of Grade 7 students are competently engaged in school learning, based on teacher assessments.
- Based on youth self-report in Grades 7 and 8, more than 80% of students feel they belong and are safe at school, and that the adults at school care about them and can be trusted.
  - 91% feel they belong and are safe at school
  - 90% feel they are a part of the school
  - 87% are happy to be the school
  - 85% feel close to the people at their school
- Three in four Grade 7 and 8 students would talk to a counsellor or other adult if they needed help.
- One in six (15%) of Manitoba's Grade 5 students have some or significant peer relationship problems (e.g., not having at least one good friend, being picked on).

## Chapter 6. Youth (Ages 13 to 19 Years/Grades 7 to 12)

Youth is the period between childhood and adulthood, and puberty marks its beginning. It is a unique period of physical, emotional, and intellectual growth. It is a time of tremendous psychosocial change, as youth face new expectations about their behaviour, and develop their identity with increasing autonomy from adults. Youth are also beginning to develop intimate relationships, often with physical and sexual intimacy. Youth is an important developmental period, particularly because patterns of both emotional and physical health in the teen years often follow individuals into adulthood and throughout their lives.<sup>227</sup>

Teens go through many physical changes. The physical changes that they are most aware of are often those associated with puberty. Hormonal changes and the development of functioning reproductive systems occur. Because puberty begins at different times for different people, and progresses at varying rates, it is common for youth to be at a different stage of physical development from their peers, making some teens self-conscious.

Physical changes in the brain during youth play an important role in youth development.<sup>228</sup> The areas of the brain associated with decision-making, planning, and emotions are enhanced. Improvements occur in logical and systematic thinking, allowing youth to make increasingly sophisticated judgments and solve more complex problems.<sup>58</sup> The abilities to control impulses, weigh the consequences of decisions, and to prioritize and strategize continue to develop into the early 20s.<sup>229</sup> Thus, although teens have increased capabilities, they do not always have the ability to manage or regulate their abilities and emotions. Adults may view their behaviour as impulsive and reckless without understanding that the areas of the brain that affect these behaviours are still developing.

In the teen years, sexual maturation and hormonal changes combine with peer pressure and societal influences to have a substantial impact on youth behaviour. This can be evident in impulsive and risk-taking behaviours as youth may experiment with alcohol and other substances. They may participate in sexual relationships. Issues such as pregnancy, sexually transmitted infections, substance use, and mental illness become increasingly significant.<sup>70</sup> Despite an increase in risk-taking behaviours, youth provides many opportunities for positive growth. Labelling youth as a problematic period in development distracts attention from these positive opportunities.

Friendships become increasingly important in youth.<sup>141</sup> Parents may feel that they are less able to influence their teen, as the peer group becomes more central. However, even as youth become more capable and independent, they continue to need supportive and nurturing families. Youth evolve through a number of transitions, including new experiences in the labour force, the development of autonomous and responsible relationships with others, and the formation of self-concept and identity.<sup>230</sup> Families and communities help prepare them for these transitions, and teens become increasingly active participants in this preparation process.

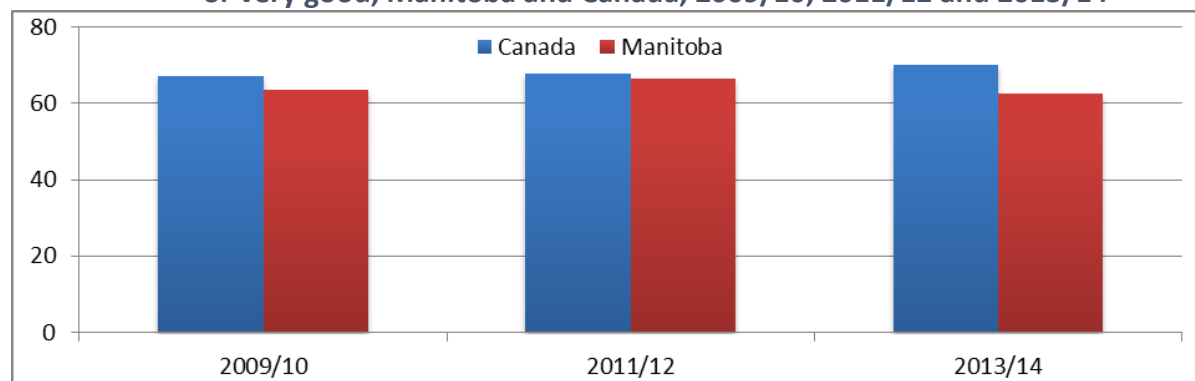
### 6.1 Physically Healthy

#### 6.1.1 Self-Rated Health

Research shows that self-rated health is a good predictor of other measures of physical health.

In 2013/14, 63% of Manitoba youth aged 15 to 19 years reported that their health was excellent or very good. That was the case for 70% of young people in Canada overall. In 2011/12, 67% of Manitoba youth aged 15 to 19 years of age reported that their health was excellent or very good; in 2009/10 that percentage was 64% (Figure 6.134).

**Figure 6.134 Per cent of Manitoba youth ages 15 to 19 who report their health is excellent or very good, Manitoba and Canada, 2009/10, 2011/12 and 2013/14**

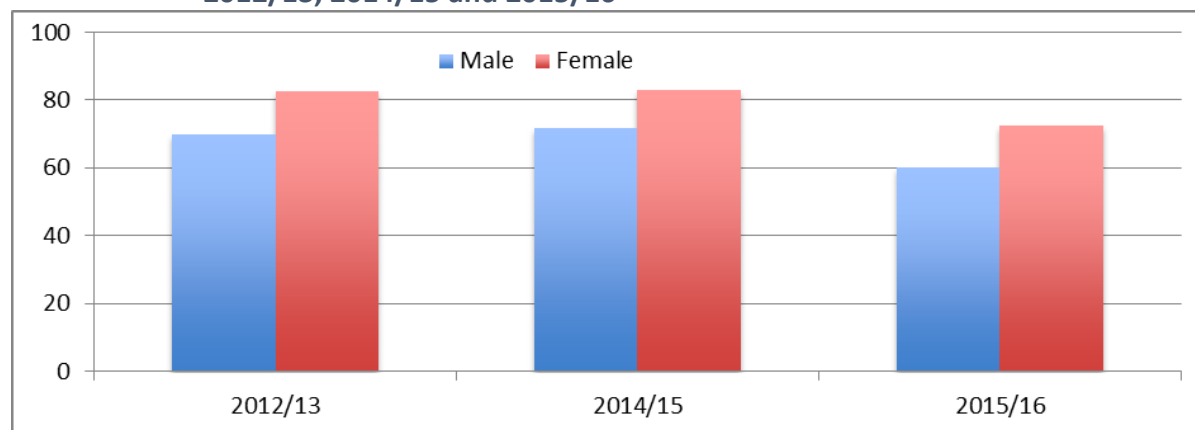


Source: Canadian Community Health Survey 2013-2014, Public Use Data Set, Accessed through ODESI.  
 Note: The Canadian Community Health Survey does not include families living in First Nations Communities.

### 6.1.2 Access to Care

Having access to physician care is important for Manitoba youth. Young women were found to be more likely to use physician services compared to young men, and both used physician services less in 2015/16 compared to 2012/13 and 2014/15. In 2012/13, 83% of young women used physician services compared to 73% in 2015/16. In 2012/13, 70% of young men used physician services compared to 60% in 2015/16 (Figure 6.135).

**Figure 6.135 Per cent of youth ages 15 to 19 using physician services, by gender, Manitoba, 2012/13, 2014/15 and 2015/16**



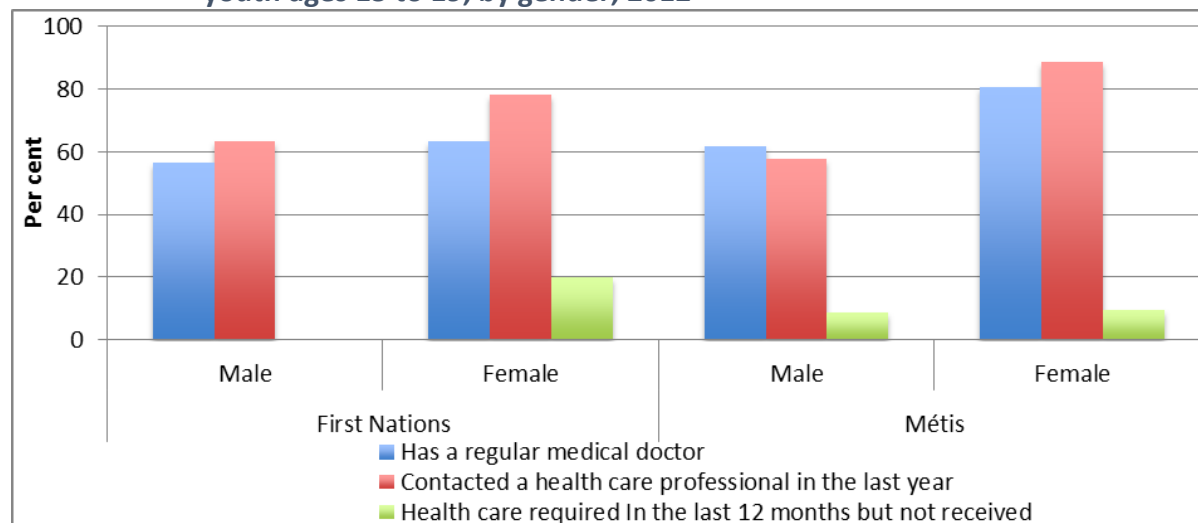
Source: Manitoba Health, Seniors and Active Living, Annual Statistics, 2012/13, 2014/15 and 2015/16.

According to Statistics Canada, young First Nations or Métis women ages 15 to 19 were more likely to access healthcare professional services than young men. Young First Nations women were more likely to have a regular medical doctor (64%) than are young First Nations men (56%). Young First Nations women were also more likely to have contacted a healthcare professional (78%) compared to young First Nations men (63%). The survey also revealed that

20% of young First Nations women required health care but were not able to receive it (Figure 6.136).

The majority of young Métis women (81%) ages 15 to 19 had a regular medical doctor and 89% contacted a healthcare professional in the last year. A lower percentage of young Métis men who had a regular medical doctor (62%) and contacted a healthcare professional in the last year (58%) (Figure 6.136).

**Figure 6.136 Contact with health care professionals, First Nations (off-reserve) and Métis youth ages 15 to 19, by gender, 2012**



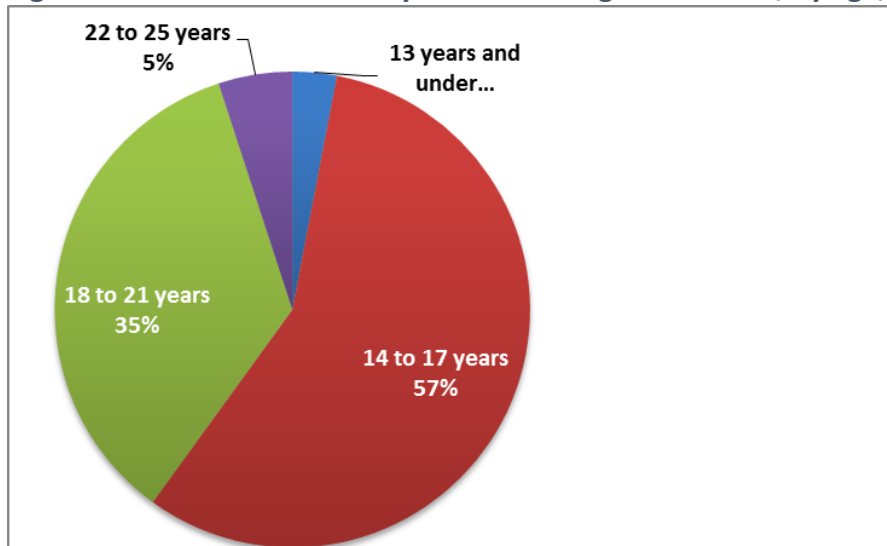
Source: Statistics Canada. Table 577-0003 - Aboriginal Peoples Survey, access to and use of health care services, by Aboriginal identity, age group and sex, population aged 6 years and over, Canada, provinces and territories, occasional. (Accessed October 03, 2017) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=5770003&p2=33>  
 Note: Does not include First Nations people living on reserve.

### 6.1.2.1 Teen Clinics

#### Who comes to a Teen Clinic?

Data are currently collected from 14 clinics, which includes urban, rural and northern sites, funded by Healthy Child Manitoba Office. In 2016/17, the total number of youth seen at 14 Teen Clinics was 5,238. The main reasons youth visit a Teen Clinic are for sexual health (fertility control, sexually transmitted infection, or pregnancy test), followed by mental health/crisis issues. The majority (57%) of youth attending the clinics are ages 14 to 17 years and 35% are ages 18 to 21 years (Figure 6.137); 92% are female and 8% male.

**Figure 6.137 Distribution of youth attending Teen Clinics, by age, Manitoba, 2016/17**



Source: Information Management and Analytics, Manitoba Health, Seniors & Active Living.

### Teen Clinics

Teen Clinics provide youth-centred integrated primary health and mental health services across the province. The Manitoba Teen Clinic model includes provision of low-barrier, early intervention services at a dedicated time with consistent health care providers. Teen Clinics work from a harm reduction, pro-choice and LGBT2SQ-positive service delivery approach and can provide help with any health problem, including access to free or low-cost birth control, and pregnancy and sexually transmitted infection testing. Youth over age 13 years can be clients in a Teen Clinic with the upper age range in some clinics being age 25 years. In 2016/17, there were 42 Teen Clinic sites operating in schools or community-based settings in Manitoba. The goals of youth-centred health care services are to:

- ensure young people in Manitoba have access to health services that are accessible and appropriate to their needs;
- provide young people transitioning to adulthood with opportunities to learn about the health issues that concern them, identify strategies for maintaining good health and access health promotion tools and resources; and
- provide young people with accurate, non-judgmental information and respectful care that acknowledges the diversity of cultures and values of all young people and recognizes gender-specific needs.

### 6.1.3 Chronic Conditions

The *Healthy Environments, Healthy People. 2015 Health Status of Manitobans Report*<sup>31</sup> states:

“Type 2 diabetes is the fastest growing chronic illness in Canada. Originally thought to be a disease that only occurred in adults, often referred to as ‘adult onset diabetes,’ this chronic illness is now being seen in children.<sup>231</sup> This rise is mirrored by an increasing trend toward childhood obesity and physical inactivity.

Manitoba currently has one of the highest rates of Type 2 diabetes in children in the world, and the number of children in Manitoba with Type 2 diabetes is 12 times higher than any other province in Canada.<sup>31</sup> Type 2 diagnoses prior to age 20 dramatically increase the risk for debilitating complications including kidney disease, blindness and amputations.”<sup>231</sup>

#### 6.1.4 Disability

As students enter the senior years, they must begin to plan for their options in life after high school. Students with exceptional needs may require supports from the provincial government, its agencies and/or Regional Health Authorities after leaving school. The transition planning process facilitates timely access to available adult supports for students with mental, learning, physical and psychiatric disabilities; persons with spinal cord injuries and persons with a visual disability or who are Deaf or hard of hearing.

#### 6.1.5 Developmental Disorders

The prevalence of developmental disorders<sup>m</sup> among youth aged 13 to 19 years was 3% between 2009/10-2012/13. This was an increase from 2% in 2005/06-2008/09. The prevalence increased in all regions of the province. During both periods, Southern Health/Santé Sud had the lowest prevalence while the Northern Region had the highest prevalence.<sup>143</sup>

##### 6.1.5.1 Attention Deficit Hyperactivity Disorder (ADHD)

Although typically diagnosed in childhood, ADHD<sup>n</sup> is considered to be a chronic condition that often persists into adulthood.<sup>70</sup> In the four years from 2009/10 to 2012/13, the prevalence rate of ADHD among youth 13 to 19 years was 4.8%. This prevalence rate was up from 3.7% in the prior four-year time period 2005/06 to 2008/09 (Figure 6.138). ADHD prevalence among boys was more than twice than girls.

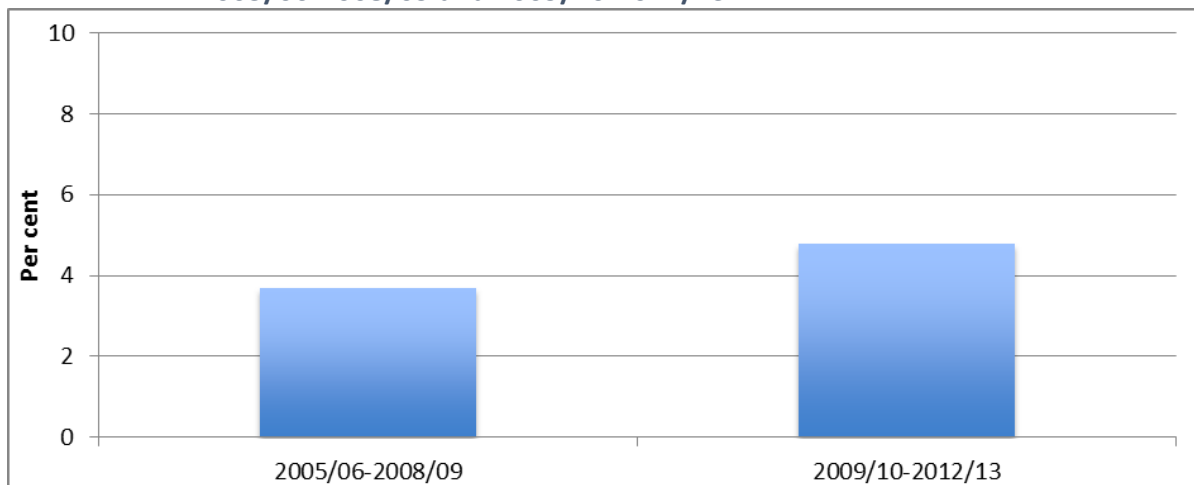
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<sup>m</sup> In study, a child (aged 0-19) is considered to have a diagnosis of developmental disorders in either time period when he/she has met at least one of the following criteria in his/her lifetime: at least one hospitalization with a diagnosis for conditions such as mental retardation, chromosomal anomalies (including Down's, Patau's and Edward's syndromes), and Autism Spectrum Disorders (ASD); at least one physician visit with a diagnosis for conditions such as mental retardation, chromosomal anomalies (including Down's, Patau's and Edward's syndromes), and Autism Spectrum Disorders (ASD); received education funding for special needs; or has been assessed for FASD at the Manitoba FASD Centre. 4 year prevalence were calculated which refers to any diagnosis over a 4 year period (either 2005/06-2008/09 or 2009/10-2012/13). With the exception of developmental disorders and ASD for which a lifetime prevalence (from child's birth to the age at the end of the study period [2012/13]) is calculated.

<sup>n</sup> In the MCHP study, a child (aged 6-19) is considered to have a diagnosis of ADHD in either time period when he/she meets at least one of the following criteria: At least one hospitalization with a diagnosis of hyperkinetic syndrome; At least one physician visit with a diagnosis of hyperkinetic syndrome; At least two prescriptions for ADHD drugs without a diagnosis of conduct disorder, disturbance of emotions, or cataplexy/narcolepsy; or at least one prescription for ADHD drugs and a diagnosis of hyperkinetic syndrome in the previous three years.



**Figure 6.138 4-year prevalence rates of ADHD among youth ages 13 to 19, Manitoba, 2005/06-2008/09 and 2009/10-2012/13**



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, Burchill C, Hu M, Rajotte L, Kulbaba C. The Mental Health of Manitoba's Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. Retrieved on August 19th 2017 from: [http://mchp.appserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp.appserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf)

Note: 4 year prevalence refers to any diagnosis over a 4 year period (either 2005/06-2008/09 or 2009/10-2012/13).

The prevalence of ADHD among children and youth aged 6 to 19 years is higher in urban areas than in rural areas. In urban communities, the prevalence increases as neighbourhood income decreases. However, in rural areas, ADHD the prevalence increases as income increases.<sup>143</sup>

#### 6.1.5.2 Autism Spectrum Disorder (ASD)

Among 13- to 19-year-olds in Manitoba, the prevalence of ASD<sup>o</sup> was 1.2% in 2009/10-2012/13. This was up from 0.7% in 2005/06-2008/09. ASD prevalence increased in all regions of the province. The prevalence was lower in Southern Health/Santé Sud in both time periods and higher in the Winnipeg RHA. The prevalence of ASD among children aged 0 to 19 years is higher in urban areas than in rural areas. In urban communities, prevalence increases as income decreases; however, in rural areas, ASD prevalence increases as income increases.<sup>143</sup>

#### 6.1.5.3 Fetal Alcohol Spectrum Disorder (FASD)

FASD is a range of lifelong neurological, behavioural, and/or physical issues that can result in impairments to cognitive and behavioural functioning. Establishing and nurturing healthy relationships are effective ways of supporting youth (and adults) with FASD who are experiencing trouble with memory, understanding cause and effect, getting used to changes in routine, sensory stimulation, learning life skills.<sup>232</sup>

<sup>o</sup> In this study, a child (aged 0-19) is considered to have a diagnosis of ASD in either time period when he/she has met at least one of the following criteria in his/her lifetime: At least one hospitalization with a diagnosis of ASD; or at least one physician visit with a diagnosis of ASD; or received education funding for special needs. The 4-year prevalence was calculated which refers to any diagnosis over a 4-year period (either 2005/06-2008/09 or 2009/10-2012/13). With the exception of developmental disorders and ASD for which a lifetime prevalence (from child's birth to the age at the end of the study period [2012/13]) is calculated.

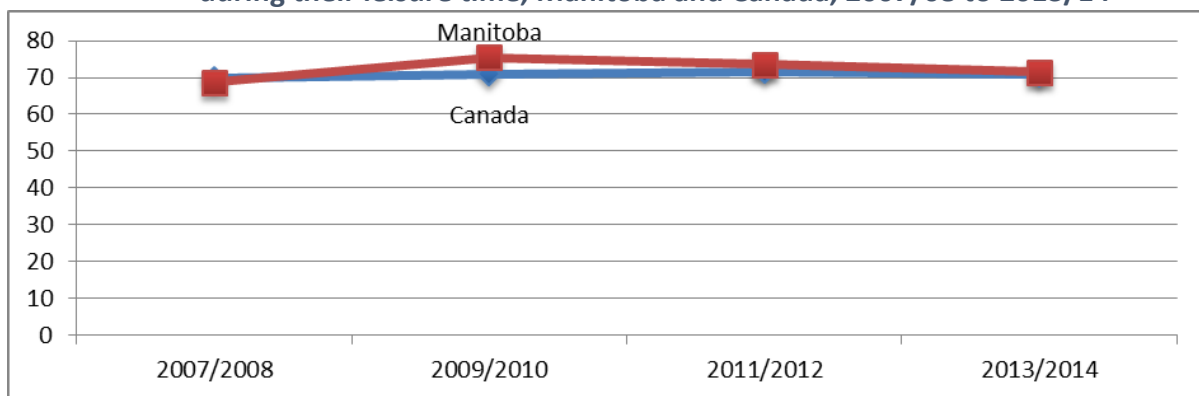
### 6.1.6 Physical Activity

Many of the health practices that contribute to health and well-being in adulthood are established or strengthened during youth, often becoming a lifelong pattern.<sup>233</sup> These practices may include physical activity, healthy eating, and substance use or abuse.

Physical activity has a positive influence on both physical and mental health. It is related to reduced risk for chronic diseases, reduced stress and improved self-esteem for youth. An active, or even a moderately active lifestyle leads to a higher quality of life.<sup>31</sup>

According to the Canadian Community Health Survey, 72% of 12- to 19-year-olds in Manitoba reported moderately active or active levels of physical activity during leisure time in 2013/14, similar to the percentage in Canada (71%) (Figure 6.139). Physical activity during leisure time was stable between 2007/08 and 2013/14 (Figure 6.139).

**Figure 6.139** Per cent of youth ages 12 to 19 who are moderately physically active or active during their leisure time, Manitoba and Canada, 2007/08 to 2013/14

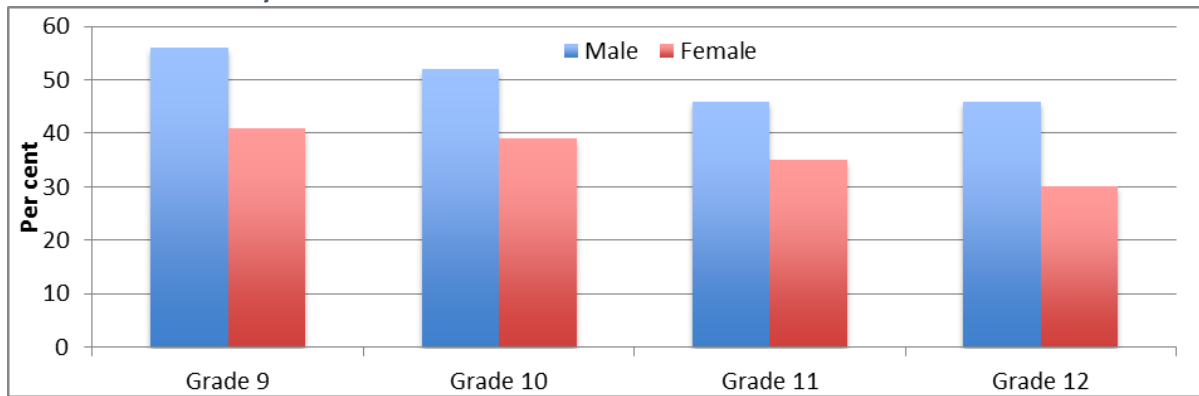


Source: Statistics Canada. Table 105-0502 – Health indicator profile, 2 year period estimates, by age group and sex, Canada, provinces, territories, health regions (2013 boundaries) and peer groups. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1050502> (accessed: September 26, 2017).

Note: The Canadian Community Health Survey does not include families living in First Nations Communities.

It is recommended that youth are active for at least 60 minutes daily. This improves their health by increasing fitness and strength, happiness, academic performance, self-confidence; helps them to learn new skills; and enables them to maintain a healthy body weight.<sup>234</sup> As Manitoba youth get older, they are less likely to meet the recommended physical activity guidelines. According to the Manitoba Youth Health Survey, 51% of Grade 7 students meet these guidelines, decreasing to 39% by the time students enter Grade 12. More boys are physically active than girls (Figure 6.140).

**Figure 6.140 Per cent of youth in Grades 9 to 12 who are active, by gender, Manitoba, 2012/13**

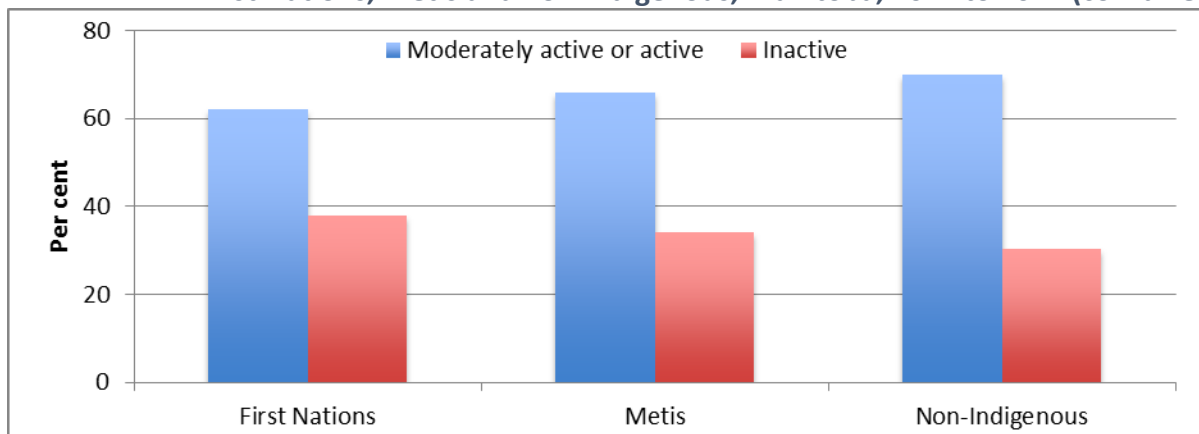


Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017. Note: Based on reported vigorous and moderate physical activity, students were placed in one of three categories: active, moderately active, or inactive. Students in the active category reported approximately 60 minutes of physical activity on a daily basis.

Youth identified barriers to physical activity. The leading barrier for males was that they had other responsibilities (32%), followed by the fact that it was hard to find the time (26%), the activities available did not interest them (23%), and they did not have a place to be active (12%). For females, the leading barrier was that it was hard to find the time (43%), followed by other responsibilities (41%), the activities did not interest them (30%), and their family was not active (16%).<sup>157</sup>

According to the Canadian Community Health Survey, 62% of Manitoba First Nations youth ages 12 to 24 reported that they were moderately active or active in the combined years 2011-2014, compared to 66% of Métis youth and 70% of non-Indigenous youth (Figure 6.141).

**Figure 6.141 Per cent of youth ages 12 to 24 who are moderately active or active or inactive, First Nations, Métis and non-Indigenous, Manitoba, 2011 to 2014 (combined)**



Source: Statistics Canada. Table 105-0512 - Health indicator profile, by Aboriginal identity, age group and sex, four-year estimates, Canada, provinces and territories, occasional (rate). Accessed: September 27, 2017. <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050512&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=> . Note: Does not include First Nations children/youth living on reserve.

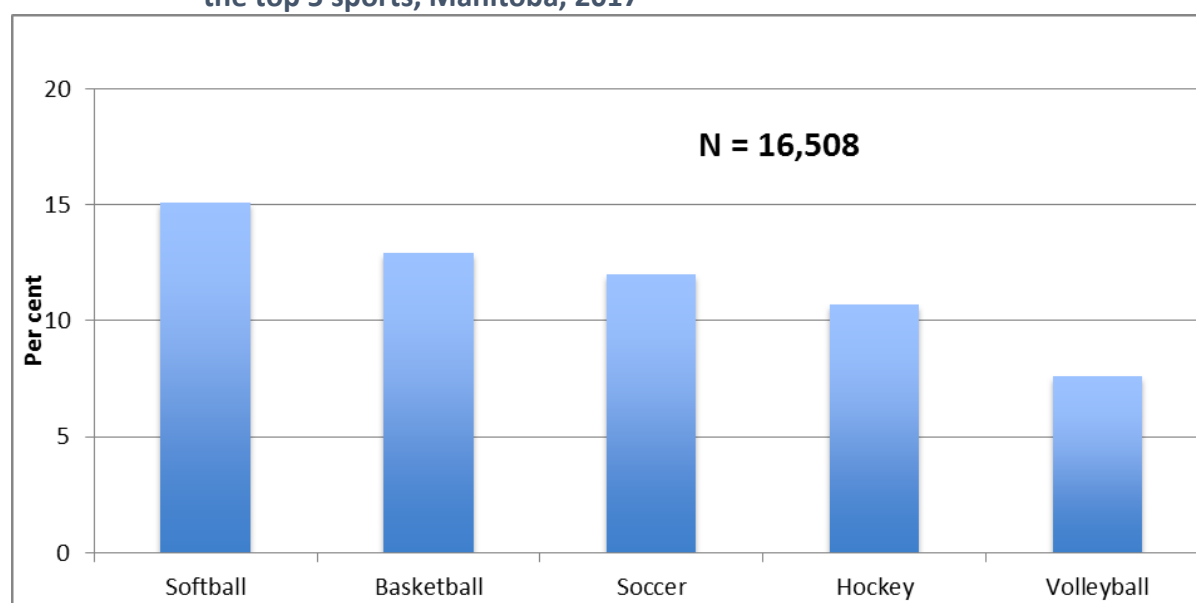
Over half of Manitoba youth (58%) in Grades 7 to 12 reported that they participated in extracurricular physical activity that was organized by their school in the past month, 58% in physical activity organized outside of their school with a coach, and 84% activities without a

coach or instructor.<sup>157</sup> Young men were more likely than young women to participate in all three kinds of activities.

Across all age groups, Canadian women and girls consistently participate in sport at lower rates than Canadian men and boys. Participating in sport brings positive physical, psychological and social benefits.<sup>235</sup>

In 2016/17, there were 16,508 young women 13 to 17 years of age who were competitive athletes in Manitoba: 15% of the young women were playing softball, 13% basketball, 12% soccer, and 11% hockey (Figure 6.142). There were also over 15,000 girls under age 13 who were competitive athletes.

**Figure 6.142 Per cent of young women competitive athletes ages 13 to 17 participating in the top 5 sports, Manitoba, 2017**



Source: Sport Manitoba, 2017

### 6.1.7 Screen Time

Technology has changed dramatically in the last decade, with portable, personal devices becoming the norm. In 2013, MediaSmarts conducted a national survey of 5,436 Canadian students, Grades 4 to 11 in every province and territory. They found that 99% of students surveyed had access to the internet outside of school and 85% of Grade 11 students used their own cell phones.<sup>236</sup>

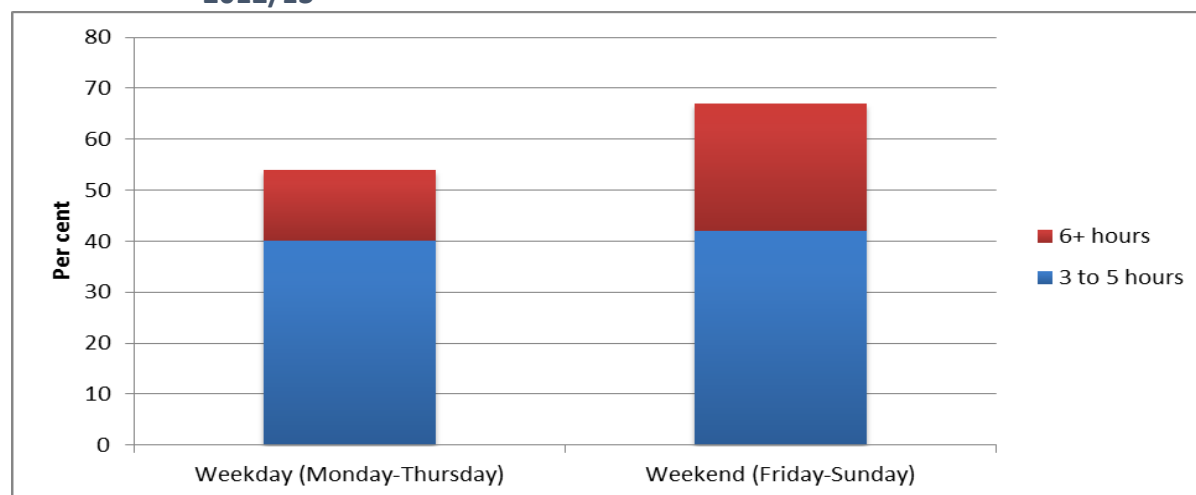
Students went online to get information about news, health issues or relationships (78%) and to ask experts or other students about personal problems (33%). A higher percentage of students in Grades 7 to 11 sought information on topics such as mental health, sexuality, physical health and relationship problems. Entertainment and communications with friends and family was the most frequent use.<sup>236</sup>

Research suggests that increased sedentary screen time spent watching TV, playing computer games, or connecting with others is one of many complex and interactive factors contributing to declining levels of fitness and nutrition, sleeping problems, and obesity.<sup>162</sup>

It is recommended that youth recreational screen time be limited to no more than 2 hours per day, because lower levels are associated with additional health benefits.<sup>164</sup>

According to the Manitoba Youth Health Survey, 54% of students in Grades 9 to 12 spent 3 or more hours a day on screen time (watching TV/movies, playing video/computer games, chatting, texting and surfing the internet) from Monday to Thursday. On the weekends (Friday to Sunday) screen time increased to 67% (Figure 6.143).

**Figure 6.143 Weekday and Weekend Screen Time per week, Manitoba, Grades 9-12, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017. Note: The survey question is: In a typical week, mark how many hours (outside of school) you spend in front of a screen, for example, watching TV/movies, playing video/computer games, chatting, text message and surfing the internet (e.g., Facebook, Twitter, etc.).

The proportion of youth spending 3 hours or more on screen time on weekdays was higher for Grade 9 to 12 students (54%) than it was for students in Grades 7 and 8 (43%). The same held true for weekends where 59% of Grade 7 and 8 and 67% of Grade 9 to 12 students spent 3 or more hours on screen time as do.

### 6.1.8 Nutrition

Nutritional needs increase during adolescence, and males and females need to eat different amounts of various nutrients for optimal growth and development. Health Canada provides daily guidelines for teenagers ages 14 to 18 (Table 6.3).

**Table 6.3 Health Canada Food Guidelines**

	Females	Males
Vegetables and fruit	7 servings	8 servings
Grain products	6 servings	7 servings
Milk and alternatives	3 to 4 servings	3 to 4 servings
Meat and alternatives	2 servings	3 servings

Source: Government of Canada. How much food you need everyday. Ottawa, ON: Health Canada. Available from: <https://www.canada.ca/en/health-canada/services/food-nutrition/canada-food-guide/food-guide-basics/much-food-you-need-every-day.html> (Accessed March 9, 2018)

On the Manitoba Youth Health Survey, 39% of young men in Grades 9 to 12 reported eating vegetables and fruit at least 7 times a day. Fewer young women, 33%, reported eating that

quantity of vegetables and fruit. Fewer students in Grades 9 to 12 eat vegetables and fruit 7 times a day than do students in Grades 7 and 8. This is the case for both young men and young women.<sup>157</sup>

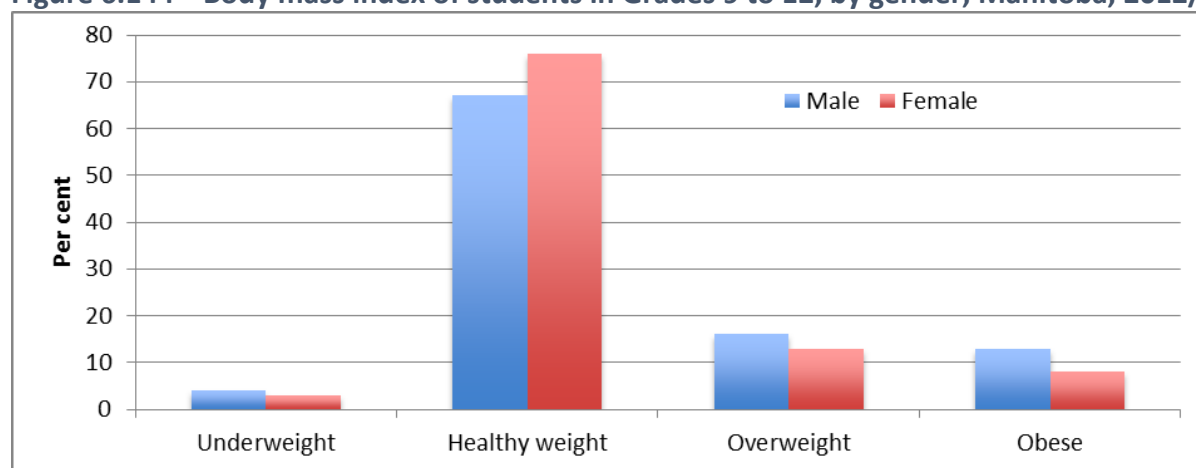
Breakfast is an important meal for young people. Youth who eat breakfast have better concentration levels, are more able to solve problems, and have better creative thinking skills. In addition, eating breakfast reduces hunger and helps young people maintain a healthy weight.<sup>237,238</sup> In 2012/13, 30% of female and 19% of male students in Grades 7 to 12 in Manitoba reported that they do not usually eat breakfast. The most common reasons given for not eating breakfast was because there was not enough time, could not eat early in the morning, and 4% said there was not enough food in their homes.<sup>157</sup>

### 6.1.9 Healthy Weights

As we saw in *Chapter 5. Middle Childhood (Ages 6 to 14 Years/Grades 1 to 8)*, the Canadian Community Health Survey reported that 26% of Manitoba children and youth ages 12 to 19 were either overweight or obese in 2013/14.<sup>25</sup> This was up from 22% in 2007/08. The proportion of Manitoba children and youth who are overweight or obese is higher than that of the overall Canadian youth population.

In 2012/13, 69% of students in Grades 7 and 8 and 72% of students in Grades 9 to 12 had healthy weights (Figure 6.144). Self-perceptions of weight differ between girls and boys. Girls' self-perception of being overweight is similar to measured overweight (20% vs. 21%), whereas boys' self-perceptions are more discrepant from measured overweight (12% vs. 29%), meaning they are less likely to see themselves as overweight.<sup>157</sup>

**Figure 6.144 Body mass index of students in Grades 9 to 12, by gender, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.  
 Note: Based on self-reported height and weight, students were placed into one of four categories: underweight, healthy weight, overweight or obese. The BMI is a measure of a person's weight to height ratio (kg/m<sup>2</sup>). Although BMI is useful in providing health risk information for whole populations, it is not appropriate for individual health risk assessment.

### 6.1.10 Eating Disorders

Eating disorders are serious and can be fatal, caused by severe disturbances to eating behaviours. Eating disorders include anorexia, bulimia and binge eating disorder. It is estimated that 3% of Canadian women will be affected by an eating disorder in their lifetime, compared to

1% of men.<sup>70</sup> Eating disorders are most common in adolescence when youth make the transition to young adulthood. Obsessions with food, body weight, and shape can become overwhelming at this this stage of development.<sup>70</sup>

The Canadian Institute for Health Information (CIHI) reported that 1,585 girls and women in Canada were hospitalized for eating disorders in 2012/2013, and girls age 10 to 19 accounted for more than half of the hospitalization. The number of 10- to 19-year-olds hospitalized for an eating disorder increased by 42% in 2012/2013 compared to 2006/2007.<sup>239</sup> This same study found that depression, anxiety and stress were the three most common mental illnesses diagnosed among women with eating disorders.<sup>239</sup>

The health impacts of eating disorders can be very serious, causing hospitalizations and even death. Anorexia nervosa, for example, has the highest mortality rate of any psychiatric illness. It is estimated that 10% of people with anorexia nervosa will die within 10 years of the onset of the disorder.<sup>227</sup>

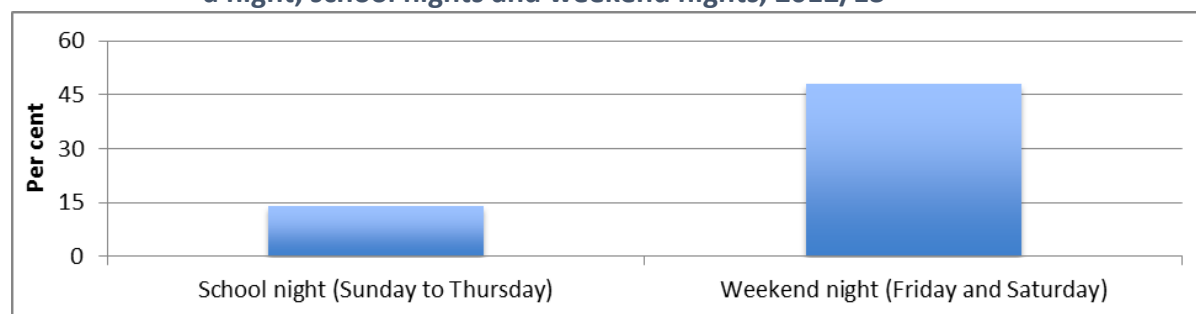
### 6.1.11 Sleep

Getting a good night's sleep is an important contributor to physical and mental health. Although there is strong evidence for the importance of sleep, Canadian society has seen a decrease in the sleep duration of all age groups, but particularly for children and youth.

Studies of Canadian high school students have reported that over 70% of students get less than the recommended amount of sleep for their age. Modern lifestyle factors that affect sleep and sleep regulation include the constant use of electronic media, excessive light exposure late in the evening, caffeine consumption, and the low priority given to sleep by families and society in general.<sup>240</sup>

Only 14% of Manitoba students in Grades 9 to 12 report that they get 9 hours of sleep or more on average on school nights (Sunday to Thursday). Meanwhile, 38% of Grade 9 to 12 students reported that they often or always had trouble going to sleep or staying asleep and 27% said that they often/always found it difficult to stay awake during class or in school. A greater proportion (48%) report getting 9 hours of sleep or more on the weekends (Figure 6.145).<sup>70</sup>

**Figure 6.145 Per cent of Manitoba youth in Grades 9 to 12 who get 9 or more hours of sleep a night, school nights and weekend nights, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

## **6.1.12 Healthy Sexuality**

### *6.1.12.1 Gender identity*

Gender identity refers to “one’s sense of oneself, as male, female or transgender.”<sup>241</sup> The term transgender is used to define individuals whose gender identity, expression, or behaviour is different from the attributes usually associated with the sex with which they were identified at birth. Not all persons whose appearance or behaviour is gender-nonconforming identify themselves as a transgender person.<sup>241</sup> A small percentage (3%) of Manitoba students in Grades 7 to 12 responded that they identify as being transgender or with a different sex than they reported in the demographic question of this survey, while 5% of students responded that they have questioned their gender identity.

### *6.1.12.2 Sexual orientation*

Sexual orientation refers to the sex of those persons to whom one is romantically and sexually attracted.<sup>242</sup> In response to questions about sexual orientation, 5% of students reported they were attracted to both males and females, while 2% of Manitoba students in Grades 7 to 12 responded they were attracted to members of the same sex that they reported in the demographic question of the survey.

Gay, lesbian, bisexual and transgender persons often experience broad social stigma such as overhearing homophobic and transphobic comments; experiencing verbal, physical and sexual harassment; and a lack of perceived safety in public areas.<sup>243</sup>

### *6.1.12.3 Supporting transgender and gender diverse youth in Manitoba schools*

The experiences of transgender (trans) and gender diverse students in Manitoba have been captured through two key studies.<sup>243,244</sup> Both studies identified that trans- and gender diverse students often experience school as unsafe environments where they face transphobic harassment, rejection, discrimination and even violence from both students and staff.

Recognizing that Manitoba is committed to creating environments where all children feel welcome and safe, in 2017, Manitoba Education and Training released the document *Supporting Transgender and Gender Diverse Students in Manitoba Schools*.<sup>245</sup> The document is intended to support schools and school boards in fulfilling a shared responsibility to promote the dignity, respect, human rights and equity of trans- and gender diverse students.

The core of the document provides guidelines to help school divisions and schools, with the involvement of students with lived experiences and their families, to develop their own policies and protocols to promote respect for and equity of trans and gender diverse students in safe, caring, and inclusive schools and learning environments.

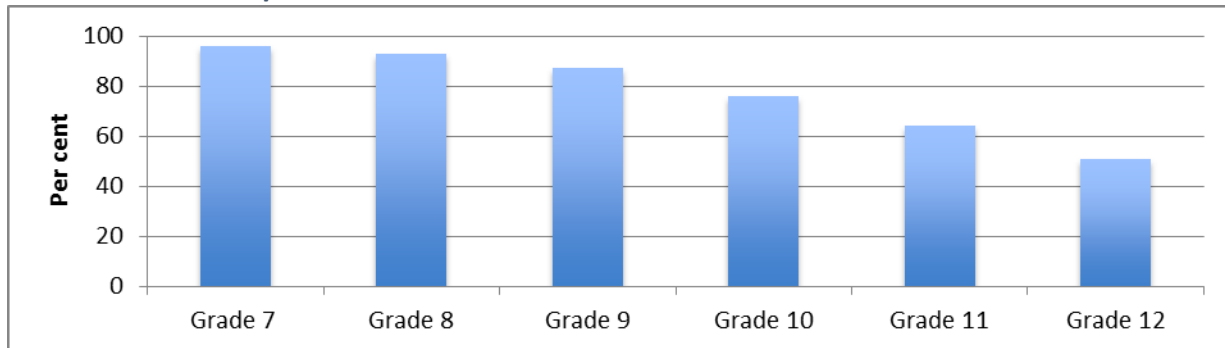
### *6.1.12.4 Sexual activity and contraception*

When youth delay having sex, they are less likely to have multiple sex partners, to acquire sexually transmitted infections including HIV, and to have an unplanned pregnancy.<sup>246,247</sup> Overall, 74% of Manitoba youth in Grades 7 to 12 reported that they have not had sex. This percentage declined with increasing grade: 96% of Grade 7 students had not had sex, while 51%



of Grade 12 students had not had sex (Figure 6.146). The most common age reported as the first time having sex was age 15 years (24%).

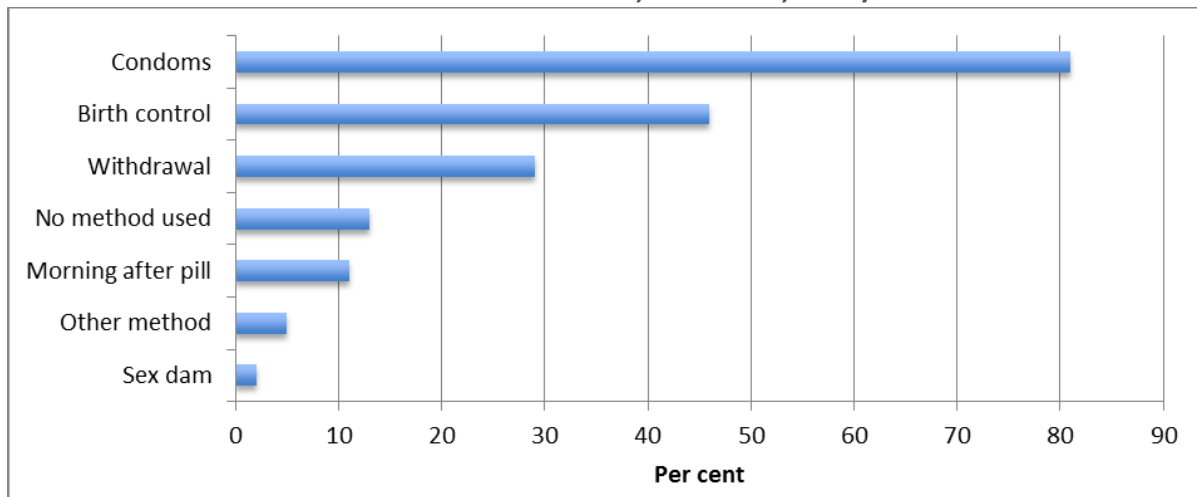
**Figure 6.146 Per cent of students in Grades 7 to 12 who have not had sex, Manitoba, 2012/2013**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

The most common method of protection against STIs and unplanned pregnancy among Grade 7 to 12 students who had sex was condoms (81%); however, 13% reported that they did not use any method of protection (Figure 6.147).

**Figure 6.147 Methods of preventing STIs and unplanned pregnancy reported by students in Grades 7 to 12 who have had sex, Manitoba, 2012/13**



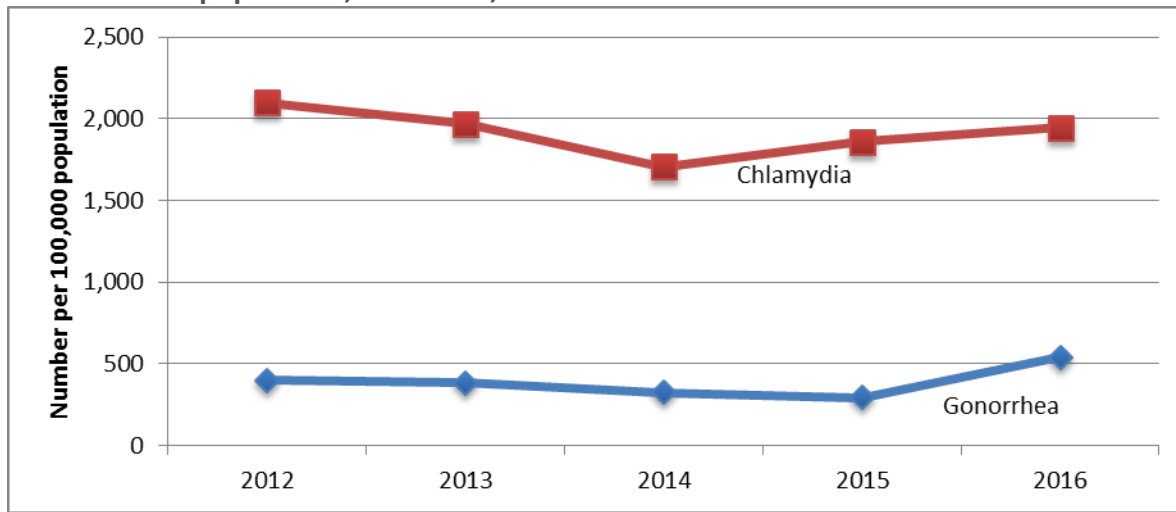
Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

Of the students who reported having sex, 17% reported that they had sex when they did not want to, and 2% reported that they had sex for money, food, shelter, drugs or alcohol. The survey reported that 51% of students were always comfortable talking with their partner about using condoms or birth control, and 37% were always comfortable talking about their sexual partner about STIs. The survey found that 37% reported that they had unplanned sex after using alcohol or drugs in the past year.

### 6.1.12.5 Sexually transmitted infections (STIs)

Manitoba continues to have high rates of STIs among young people. Between 2012 and 2016, the most commonly reported STIs in Manitoba were chlamydia and gonorrhoea. The rate of chlamydia among Manitoba youth ages 15 to 19 was 1,947 per 100,000 population in 2016. The rate had declined from 2012 to 2014, and then increased again in 2016.<sup>248</sup> The rate of gonorrhoea among Manitoba youth ages 15 to 19 was 539 per 100,000 population in 2016. That was up 35% from 2012, when it was 398 per 100,000 population (Figure 6.148).

**Figure 6.148 Rate of chlamydia and gonorrhoea in youth ages 15 to 19 per 100,000 population, Manitoba, 2012 to 2016**



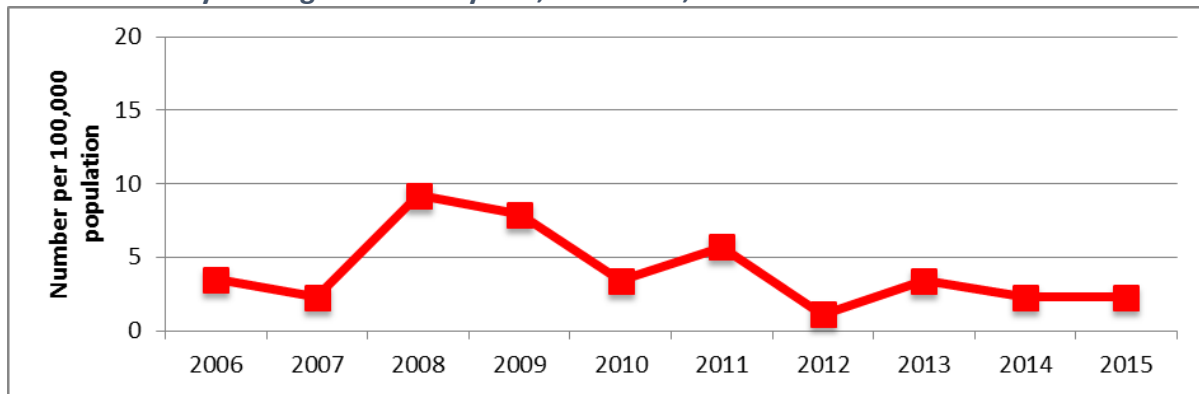
Source: Manitoba Health, Seniors and Active Living (MHSAL) Sexually Transmitted Diseases database, Jan 01, 2012 to Dec 31, 2016

Notes: The rates were calculated for the surveillance data of STIs (chlamydia, gonorrhoea, and infectious syphilis) that was extracted using ICD9 codes from MHSAL's Sexually Transmitted Diseases database from Jan 01, 2012 to Dec 31, 2016. All laboratory-confirmed STIs cases in Manitoba were reported to the Public Health Surveillance Unit and entered in the routine surveillance database. To be considered laboratory-confirmed, STIs cases must meet the provincial surveillance case definition. The surveillance data reflects only the number of individuals tested and diagnosed with STIs; it does not include individuals who have STI but have not been diagnosed.

### 6.1.12.6 HIV/AIDS

At the end of 2014, Manitoba had the fourth highest reported rate of youth and adults (15 years of age and older) newly diagnosed with HIV among the provinces and territories. Cases from Manitoba accounted for 4.2% of newly diagnosed cases in Canada in 2014.<sup>249</sup> Between 2000 and 2015 in Manitoba, there were 18 youth under the age of 15 years, and 45 youth aged 15 to 19 years who had a new positive HIV test. The rate of new HIV cases increased in 2008 but appears to have stabilized in recent years (Figure 6.149).

**Figure 6.149 Age-specific rates (per 100,000 population) for new HIV diagnoses among youth ages 15 to 19 years, Manitoba, 2006 to 2015**



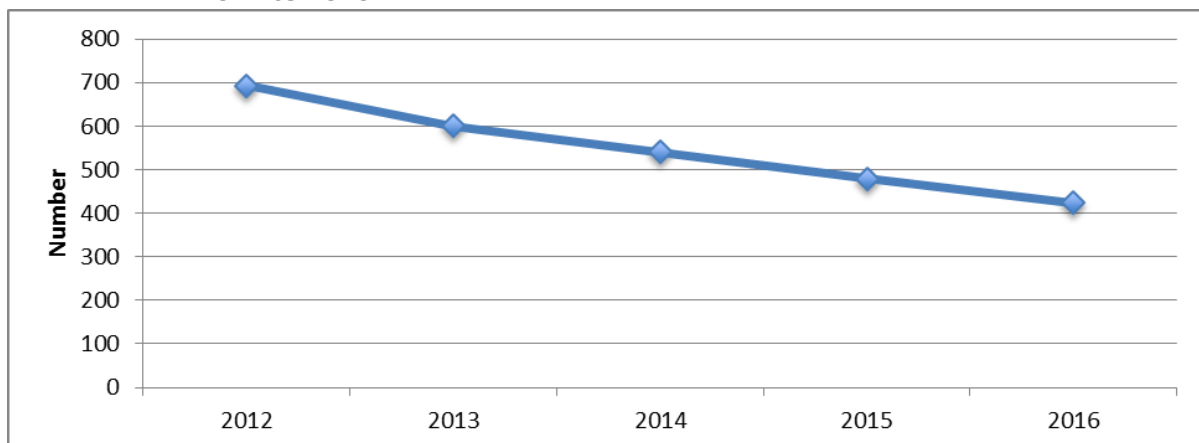
Source: Manitoba Health Statistical Updates on HIV/AIDS 2015. <http://www.gov.mb.ca/health/publichealth/surveillance/hivaids/docs/dec2015.pdf>  
 Note: Changes in the number of HIV positive individuals as well as observed trends must be interpreted with caution. There are a number of factors which may contribute to these changes, for example, changes in testing or reporting patterns among care providers.

The number of new HIV cases may not be a reflection of the true number of new HIV infections per year (i.e., incidence) in the Manitoba population. Although every effort is made to ensure that all reported cases are confirmed as new cases in Manitoba, it is possible that some repeat cases will exist.

#### 6.1.12.7 Induced abortions

Since 2012, the number of induced abortions among Manitoba youth age 19 and under has been declining steadily from 693 in 2012 to 424 in 2016 (Figure 6.150).

**Figure 6.150 Number of induced abortions among youth 19 years and under, Manitoba, 2012 to 2016**



Source: Manitoba Health population-based physician claims and hospital separation abstracts. Data provided by Active Living, Population and Public Health, Manitoba Government Health, Seniors and Active Living.

## 6.2 Mentally Healthy

The teenage years are a time of extreme physical and emotional change. For some youth, the stress that accompanies these changes exceeds their ability to cope and contributes to mental health problems, substance abuse issues, or both.<sup>250</sup>

“Mental health is much more than the absence of mental illness. It is a state of well-being where individuals:

- realize their own potential
- are happy and satisfied
- have the ability to cope with the normal stresses of life
- are able to work productively
- feel a sense of belonging and purpose
- are able to make contributions to their communities.”<sup>251</sup>

The mental health of youth is influenced by interacting factors including biology and genetics, economic status, and family, school, peer and community environment. Promoting mental health and intervening early when problems arise increases resilience and leads to optimum mental well-being through adulthood.<sup>40</sup>

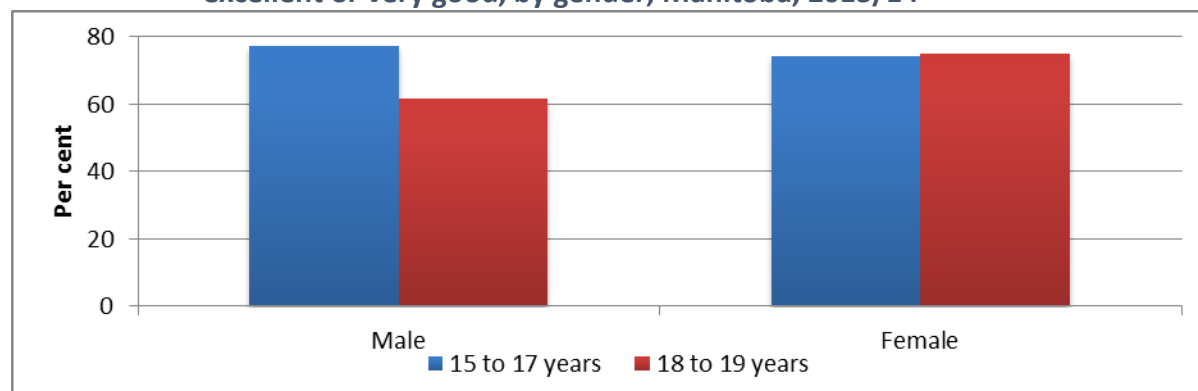
## 6.2.1 Well-Being

### 6.2.1.1 Self-rated mental health

Adolescent well-being includes positive aspects, such as life satisfaction and self-reported health, and risk behaviours.<sup>141,252</sup>

In 2013/14, 74% of Manitoba females and 77% of males ages 15 to 17 reported their mental health as excellent or very good. The rates for Manitoba males and females ages 18 to 19 were 62% and 75% respectively (Figure 6.151).

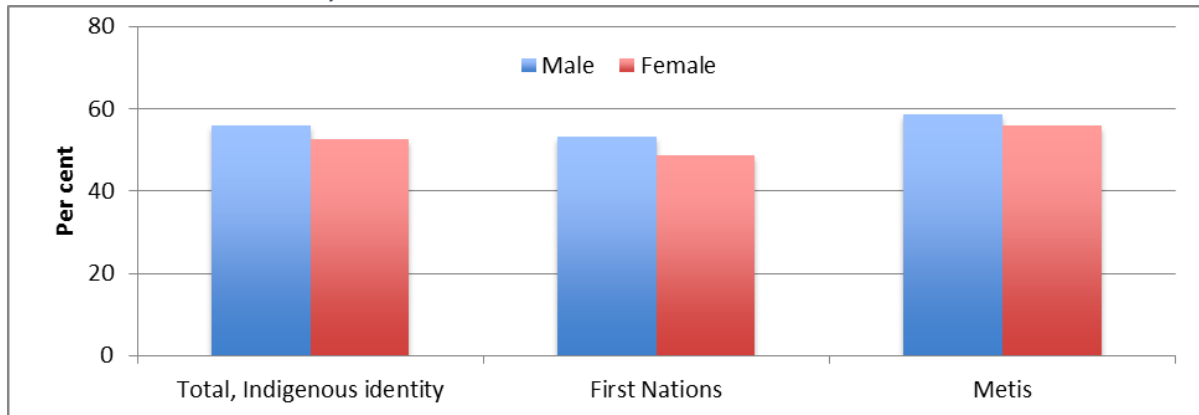
**Figure 6.151 Per cent of youth ages 15 to 17 and 18 to 19 who report their mental health is excellent or very good, by gender, Manitoba, 2013/14**



Source: Canadian Community Health Survey 2013/2014, Public Use Data Set, Accessed through ODESI on September 23rd, 2017.  
Note: The Canadian Community Health Survey does not include families living in First Nations Communities.

In Manitoba, 53% of male First Nations youth and 49% of female First Nations youth ages 18 to 24 reported their mental health to be excellent or very good. Of Métis males 18 to 24 years of age, 59% reported that their mental health was excellent or very good, as did 56% of female Métis youth (Figure 6.152).

**Figure 6.152 Per cent of Indigenous (First Nations, Métis and Inuit) youth ages 18 to 24 who report their mental health to be excellent or very good, by identity and gender, Manitoba, 2012**



Source: Statistics Canada. Table 577-0013 - Aboriginal Peoples Survey, perceived mental health and suicidal thoughts, by Aboriginal identity, age group and sex, population aged 18 years and over, Canada, provinces and territories, occasional (accessed: October 07, 2017) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=5770013&&pattern=&stByVal=1&p1=1&p2=-1&tabMode=dataTable&csid=>

Note: Excludes persons living on Indian reserves or settlements.

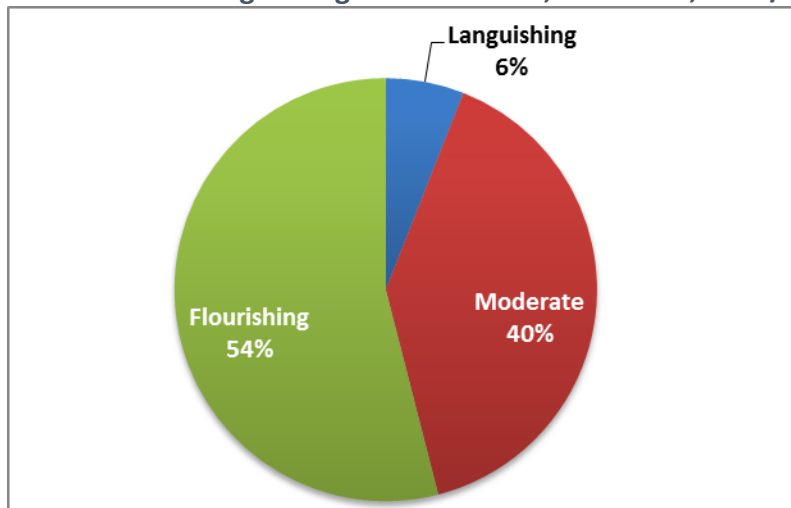
Note: Total Indigenous identity includes Inuit youth. However, the numbers are too small to report Inuit youth by gender.

The 2012/2013 Manitoba Youth Health Survey used the Mental Health Continuum Tool to measure the categories flourishing, moderate and languishing mental health.<sup>p</sup>

Overall, 54% of Grade 9 to 12 students report flourishing mental health, 40% report moderate mental health and 6% report languishing mental health (Figure 6.153). Anything less than flourishing mental health is not optimal and may in fact be a potential warning sign for poor mental health in the future. Actions to both sustain flourishing states of mental health and actions to enhance moderate or languishing states of mental health are necessary to protect and promote mental health.<sup>253</sup>

<sup>p</sup> The Mental Health Continuum Tool is based on student responses to statements related to thoughts and feelings. Students' responses are collated into one of three overall categories: flourishing, moderate or languishing. Sample questions include: During the past month, how often did you: feel happy; interested in life; that you had warm and trusting relationships with others; that your life has a sense of direction or meaning to it.

**Figure 6.153** Per cent of youth in Grades 9-12 who have flourishing, moderate, or languishing mental health, Manitoba, 2012/13



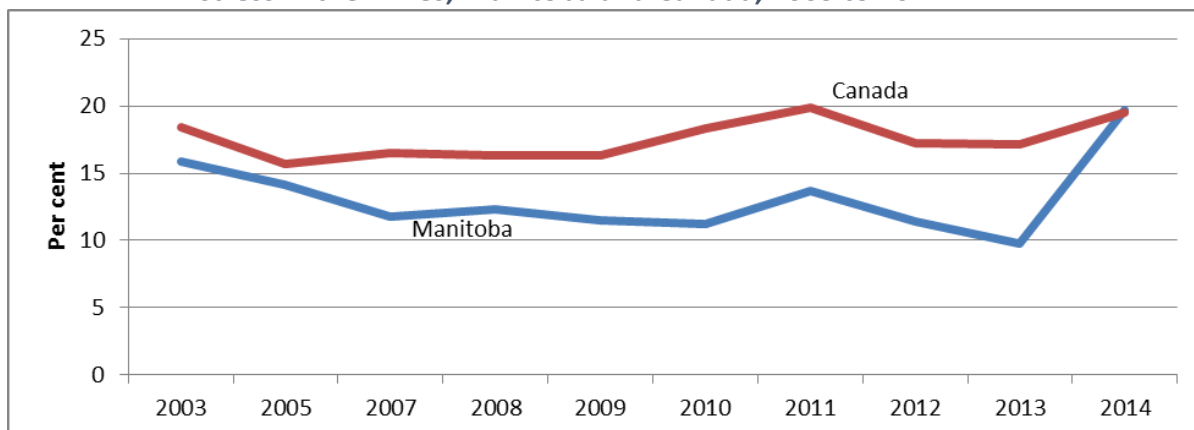
Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

### 6.2.1.2 Stress

#### *Perceived life stress*

In the Canadian Community Health Survey (2014), 20% of Manitoba youth ages 15 to 19 reported that they had quite a lot of stress in their lives. Since 2003, the Manitoba rate has been lower than the Canadian rate but converged at 20% in 2014 (Figure 6.154). In 2014, 24% of young women in Manitoba ages 15 to 19 reported that they had quite a lot of stress in their lives, compared with 16% of young men.

**Figure 6.154** Per cent of youth ages 15 to 19 who perceive that they have quite a lot of stress in their lives, Manitoba and Canada, 2003 to 2014

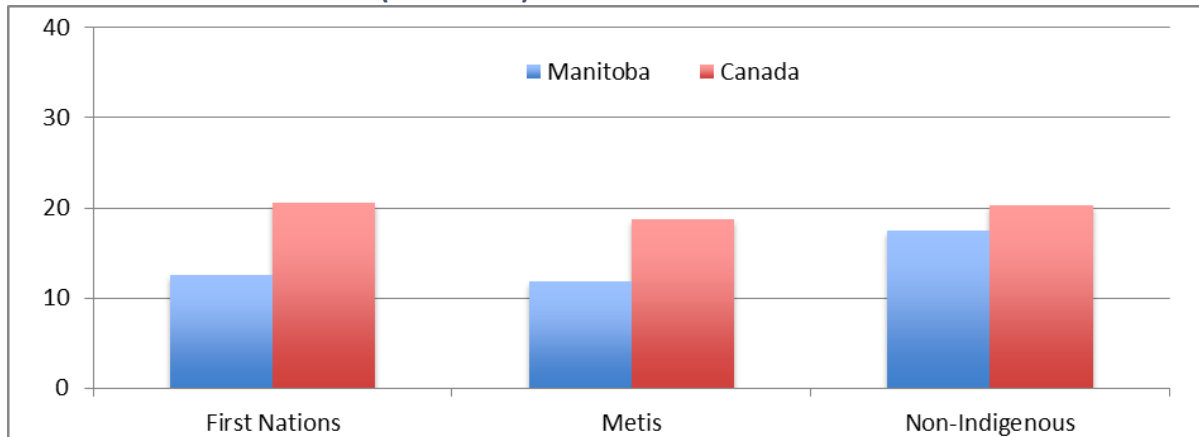


Source: Canadian Community Health Survey 2013/2014, 2011/2012, Public Use Data Set, Accessed through ODESI on September 23rd, 2017. The Canadian Community Health Survey does not include families living in First Nations Communities.

According to the Canadian Community Health Survey, 13% of Manitoba First Nations youth and 12% of Manitoba Métis youth ages 15 to 24 reported they have quite a lot of stress in their lives in the years 2011 to 2014 (combined). The Canadian overall rate was higher for First Nations youth (21%) and Métis youth (19%) (Figure 6.155).

The Manitoba non-Indigenous rate of 18% for reported life stress among 15- to 24-year-olds was higher than it was for Manitoba First Nations and Métis youth. The non-Indigenous rate for Canada overall was similar to the Canada overall rate for First Nations and Métis youth (Figure 6.155).

**Figure 6.155 Per cent of youth ages 15 to 24 who report they have quite a lot of stress in their lives, First Nations, Métis and non-Indigenous, Manitoba and Canada, 2011 to 2014 (combined)**



Source: Statistics Canada. Table 105-0512 - Health indicator profile, by Aboriginal identity, age group and sex, four-year estimates, Canada, provinces and territories, occasional (rate) (Accessed September 27, 2017) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050512&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=>  
 Note: Does not include First Nations children/youth living on reserve.

## 6.2.2 Substance Use

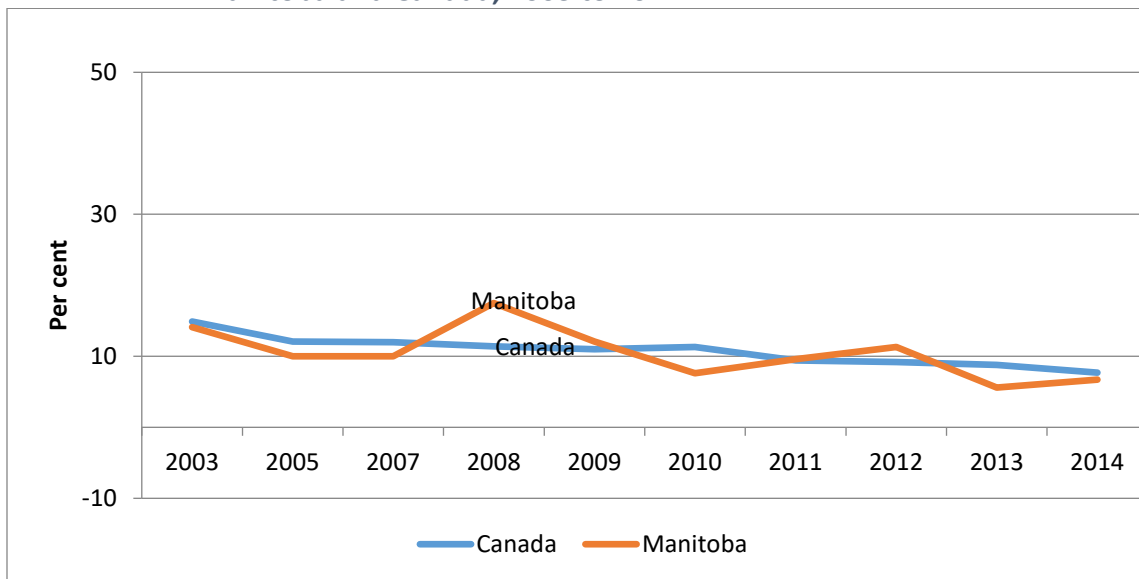
Youth often engage in risk-taking behaviours, including substance use, which may have negative consequences to brain development, relationships, school engagement and physical health.<sup>254</sup>

### 6.2.2.1 Smoking

Tobacco is one of the most addictive substances and one of the most accessible to youth. Smoking may be a way for youth to convey independence or maturity and establish their identity.<sup>227</sup> Research has shown that more than 80% of adult smokers began smoking before the age of 18. Smoking remains a leading cause of cancer, and adolescents who smoke have higher rates of respiratory illness compared to non-smokers.<sup>255</sup> Youth living in poverty are at a higher risk of smoking and have a lower success rate when trying to quit.

The number and proportion of young people smoking in Manitoba has declined in recent years. In 2014, 7% of Manitoba youth ages 12 to 19 were current smokers – either daily or occasional (Figure 6.156) – down by half from 14% in 2003. The Manitoba rate was comparable to the Canadian rate (8%) in 2014 (Figure 156). In Manitoba, 54% of youth who were smoking were daily smokers.

**Figure 6.156 Per cent of youth ages 12 to 19 who were current smokers (daily or occasional), Manitoba and Canada, 2003 to 2014**



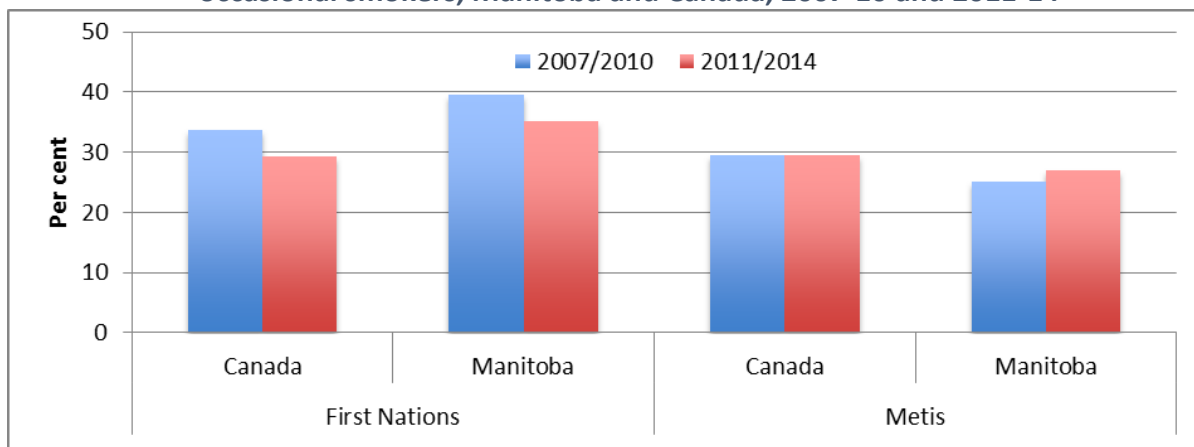
Source: Statistics Canada. Table 105-0501 - Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2013 boundaries) and peer groups, occasional (Accessed October 05, 2017) <http://www5.statcan.gc.ca/cansim/a05?lang=eng&id=1050501>

Note: The Canadian Community Health Survey does not include families living in First Nations Communities.

Smoking is more common among Manitoba's First Nations and Métis youth. In the combined years 2011 to 2014, 35% of Manitoba First Nations youth ages 12 to 24 were daily or occasional smokers compared to 29% in Canada overall (Figure 6.157). In Manitoba, this declined from 39% in 2007-2010.

In 2011-2014, 27% of Métis youth ages 12 to 24 were daily or occasional smokers, compared to 30% in Canada overall. The proportion of Métis youth smoking in Manitoba had increased from 25% in 2007-2010 (Figure 6.157).

**Figure 6.157 Per cent of First Nations and Métis youth ages 12 to 24 who are daily or occasional smokers, Manitoba and Canada, 2007-10 and 2011-14**



Source: Statistics Canada. Table 105-0512 - Health indicator profile, by Aboriginal identity, age group and sex, four-year estimates, Canada, provinces and territories, occasional (rate) (accessed: September 27, 2017) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050512&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=>

Note: Does not include First Nations children/youth living on reserve.



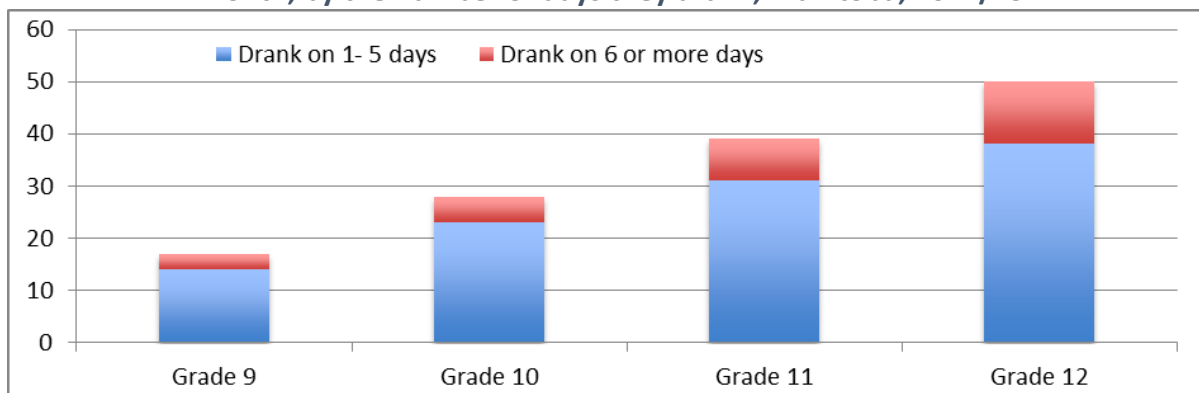
### 6.2.2.2 Alcohol use and binge drinking

Alcohol use and binge drinking are of concern for a number of reasons. One concern is impaired driving. Alcohol use and binge drinking is also of concern because it may become chronic, with harmful drinking patterns continuing into adulthood. Chronic alcohol abuse leads to a number of acute and chronic conditions, including liver and pancreatic disease.

In 2012/13, half of Grade 12 students in Manitoba reported that they had at least one drink in the past month: 38% drank alcohol on 1 to 5 days in that month, and 12% drank on 6 or more days (Figure 6.158).

The percentage of students who had at least one drink in the last month increased from Grade 9 through 12. In Grade 9, 17% had had at least one drink in the last month, 28% in Grade 10, 39% in Grade 11, and 50% in Grade 12 (Figure 6.158).

**Figure 6.158** Per cent of students in Grades 9 to 12 who had at least one drink in the last month, by the number of days they drank, Manitoba, 2012/13



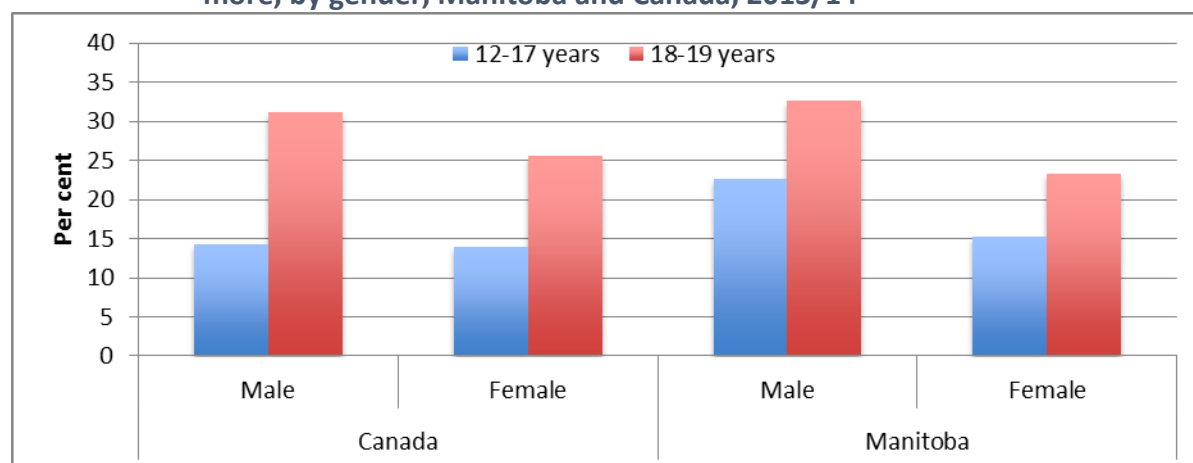
Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

In 2013/14, 23% of young men and 15% of young women in Manitoba ages 12 to 17 reported binge drinking once a month or more. Binge drinking for young women is defined as having 4 or more drinks in one sitting, and for young men it is 5 or more drinks in one sitting (Figure 6.159).<sup>25</sup>

Older teens are more likely to binge drink than younger teens. At ages 18 to 19 years, 33% of young men reported binge drinking at least once in the last month, compared to 23% of young women (Figure 6.159).

The binge drinking rate among young men 12 to 17 years was higher in Manitoba (23%) than in Canada overall (14%). The rates for young women at that age are similar in Canada and Manitoba. The binge drinking rates among older teens, 18 and 19 years, are similar for Manitoba and Canada (Figure 6.159).

**Figure 6.159** Per cent of youth ages 12 to 19 who report binge drinking once a month or more, by gender, Manitoba and Canada, 2013/14

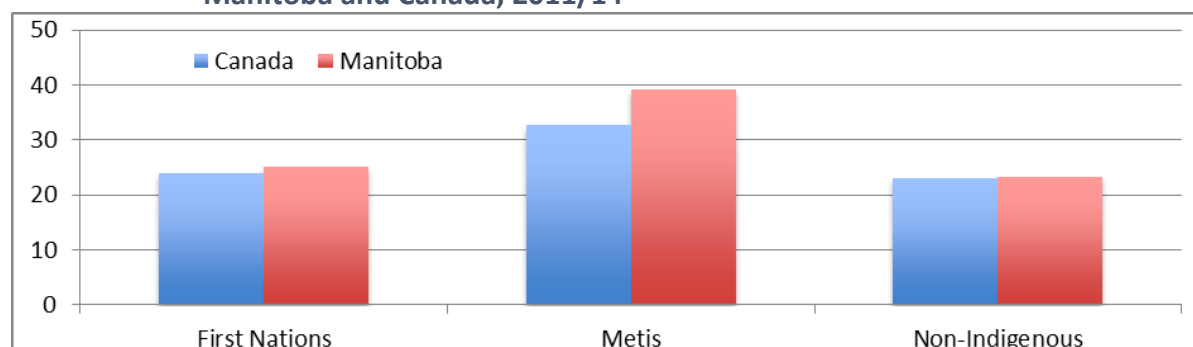


Source: Canadian Community Health Survey 2013-2014 & 2011-2012, Public Use Data Set, Accessed through ODESI.

In 2011/14, 25% of First Nations youth in Manitoba reported that they had engaged in binge drinking at least once a month in the last year. Binge drinking was defined as 5 or more drinks on one occasion. That was similar to the rate among First Nations in Canada overall (24%) (Figure 6.160).

A higher proportion of Métis youth aged 12 to 19 years engaged in binge drinking: 39% in Manitoba, and 33% in Canada overall. The rates for non-Indigenous youth in Manitoba and Canada were similar to the rates of First Nations youth at approximately 1 in 4 (Figure 6.160).

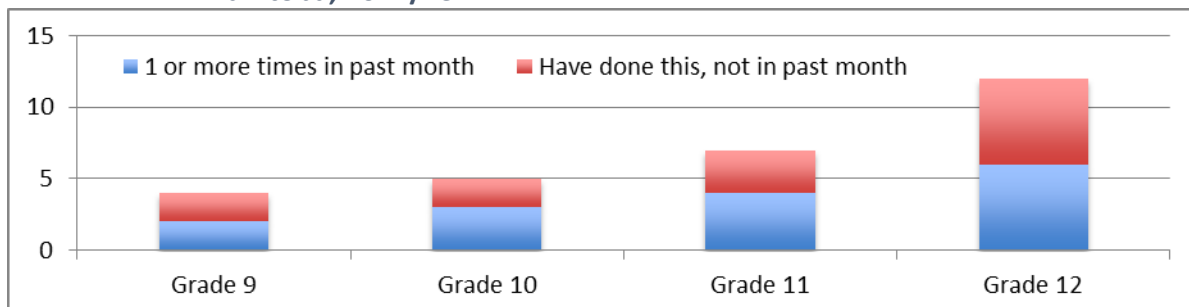
**Figure 6.160** Per cent of youth ages 12 to 19 who report binge drinking at least once a month in the last year, First Nations, Métis and non-Indigenous, Manitoba and Canada, 2011/14



Source: Statistics Canada. Table 105-0512 - Health indicator profile, by Aboriginal identity, age group and sex, four-year estimates, Canada, provinces and territories, occasional (rate) (accessed: September 27, 2017) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050512&&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=>  
 Note: Does not include First Nations children/youth living on reserve.

Motor vehicle crashes are the leading cause of death for youth 15 to 24 years of age in Manitoba, and teen drivers have the highest fatality rate of all drivers. In Manitoba, the involvement of alcohol in crashes is most common among 20- to 25-year-old victims.<sup>256</sup> According to the 2012/13 Manitoba Youth Health Survey, 12% of Manitoba Grade 12 students reported that they had driven after drinking and 6% had done so in the last month. Among Grade 9 students, 4% had driven after drinking while 2% had done so in the last month. The prevalence of driving after drinking alcohol increases with each grade (Figure 6.161).

**Figure 6.161 Per cent of students in Grades 9 to 12 who have driven after drinking, Manitoba, 2012/13**



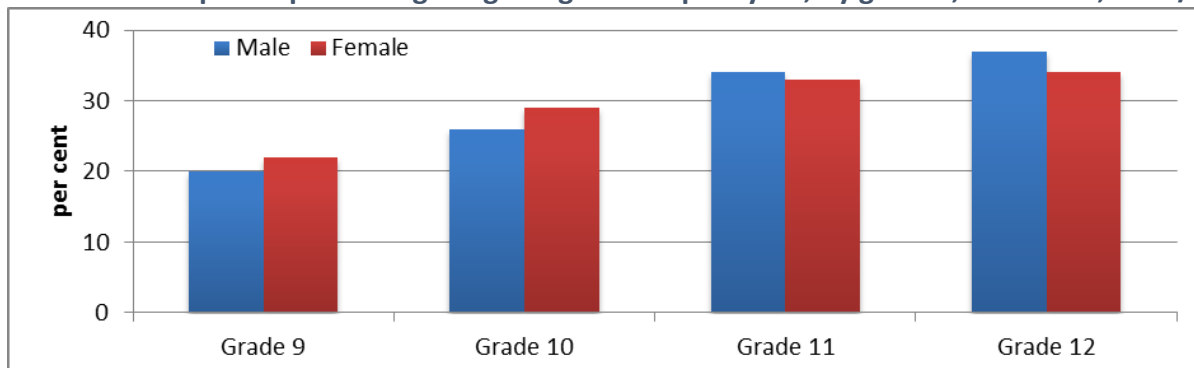
Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

### 6.2.2.3 Recreational drug use

Marijuana is the most commonly used drug in Manitoba, other than alcohol,<sup>257</sup> and the average age of first use in Canada is about 14 years.<sup>258</sup>

Results of the Manitoba Youth Health Survey indicate that recreational drug use, much like smoking and alcohol use, increases with age, for both males and females. When asked if they had used recreational or prescription drugs to get high in the past year, over a third of Grade 11 and 12 students responded yes: 37% of Grade 12 boys and 34% of Grade 12 girls. The results were similar for Grade 11 students (Figure 6.162).

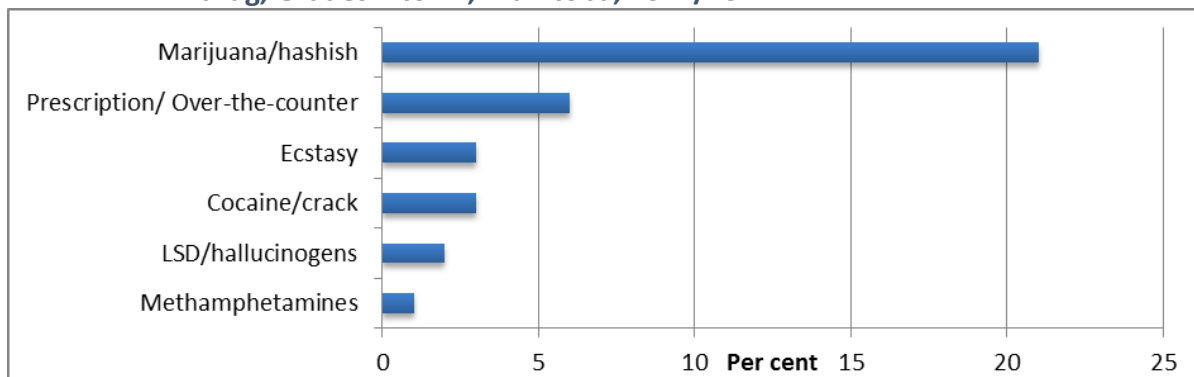
**Figure 6.162 Per cent of students in Grades 9 to 12 who have used recreational or prescription drugs to get high in the past year, by gender, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

When asked the question, “In the past year (12 months) how many times have you used marijuana/hashish, cocaine or crack, methamphetamines, ecstasy, LSD or other hallucinogens, taken a prescription or over-the-counter drug to get high?”, 21% of Manitoba youth in Grades 7 to 12 reported using marijuana/hashish, 6% reported using prescription/over-the-counter drugs, 3% used cocaine/crack, 3% used ecstasy, 2% used LSD/hallucinogens and 1% used methamphetamines (Figure 6.163).

**Figure 6.163 Per cent of students who used recreational drugs in the last year by type of drug, Grades 7 to 12, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

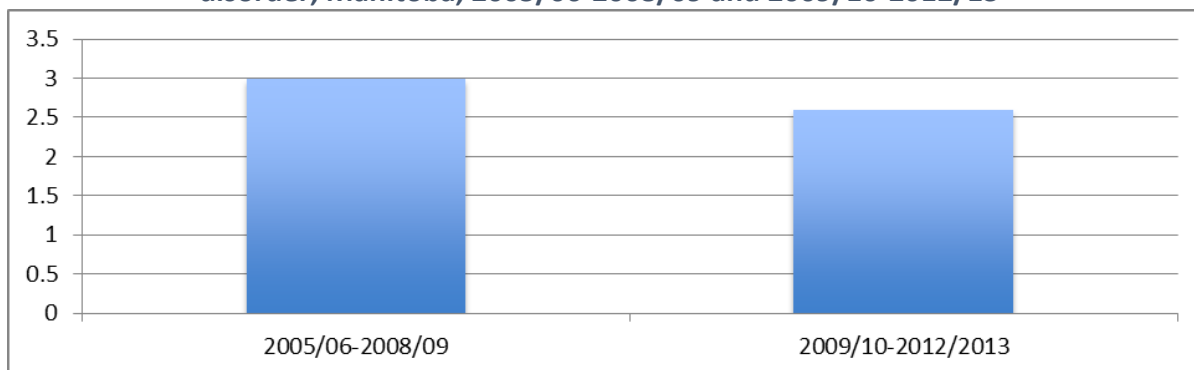
#### 6.2.2.4 Substance abuse disorder

Substance abuse and mental health problems are often linked and intertwined, becoming what is referred to as a concurrent disorder. The more severe the mental health or substance abuse problem is, the more likely it will become a concurrent disorder.<sup>250</sup>

Alone or combined, mental health problems and substance abuse can lead to damaged relationships, poor academic performance and reduced overall health. Unfortunately, these problems often persist into adulthood which makes it very important to provide youth with the help they need.<sup>250</sup>

According to a recent report from the Manitoba Centre for Health Policy, the four-year diagnostic prevalence of substance use disorders for youth aged 13 to 19 was 3% in 2005/06-2008/09 and 2.6% in 2009/10-2012/13 (Figure 6.164). In 2005/06-2008/09, 3,164 youth aged 13 to 19 were diagnosed for the first time with a substance use disorder and the number of youth diagnosed was 2,959 in 2009/12-2012/13.<sup>143</sup>

**Figure 6.164 Per cent of children and youth ages 13 to 19 diagnosed with a substance use disorder, Manitoba, 2005/06-2008/09 and 2009/10-2012/13**



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, et al. The Mental Health of Manitoba's Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. Retrieved on August 19th 2017 from: [http://mchp-ppserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp-ppserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf)  
 Note: In this study, an adolescent (aged 13-19) is considered to have a diagnosis of substance use disorders in either time period when he/she meets at least one of the following criteria: at least one hospitalization with a diagnosis for alcohol or drug psychoses, alcohol or drug dependence, or nondependent abuse of drugs; or at least one physician visit with a diagnosis for alcohol or drug psychoses, alcohol or drug dependence, or nondependent abuse of drugs.

In both time periods, the prevalence of substance use disorders in Southern Health/Santé Sud was lower than the Manitoba prevalence and in the second time period, it was lower in Winnipeg than the Manitoba prevalence. Conversely, the prevalence was higher in the Northern Region than in Manitoba. The prevalence of substance use disorders decreased from the first time period to the second time period in the Winnipeg RHA.<sup>143</sup>

The prevalence of substance use disorder was higher in rural areas than it was in urban areas. In both rural and urban areas, young people living in higher-income neighbourhoods had lower prevalence of substance use disorder than did those in lower-income neighbourhood.<sup>143</sup>

### **6.2.3 Mental Health Disorders**

It has been estimated that 80% of all psychiatric disorders first emerge in adolescence, and research has shown that a higher percentage of girls are pharmaceutically treated for both depression and anxiety compared to boys.<sup>70</sup> Psychological and emotional health problems for youth are closely tied to adverse and stressful living situations, including low income, poor housing conditions, discrimination, and family dysfunction.<sup>259</sup> For adolescents who have immigrated to Canada, the adjustment can be difficult, and racism, conflicting cultural values, and isolation can affect their psychological health.<sup>260</sup> As noted in the section on physical health, substance use or abuse often stems from stress, victimization and trauma, suggesting that these are important considerations for mental health.

#### *6.2.3.1 Mood and anxiety disorders*

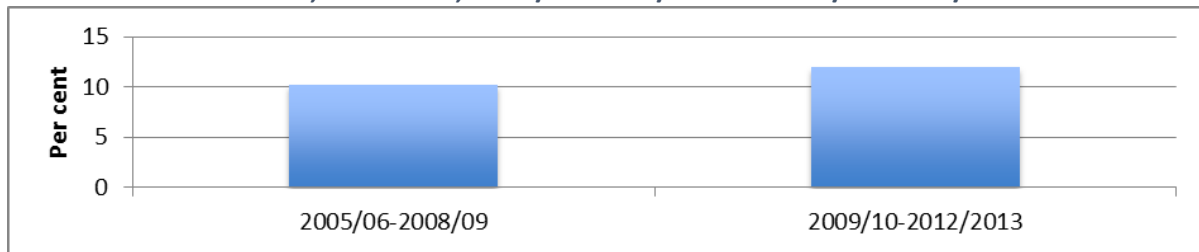
Anxiety and mood disorders include a broad group of disorders including depressive (depressed mood and lack of interest in activities), bipolar (elevated mood and increased energy), and anxiety disorders (excessive fear, anxiety or worry and often avoidance).<sup>q</sup> In 2005/06 to 2008/09, the four-year diagnosed prevalence<sup>r</sup> of mood and anxiety disorders for youth ages 13 to 19 was 10% in Manitoba. In 2009/10 to 2012/13, it had increased to 12% (Figure 6.165).

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<sup>q</sup> A child (aged 6-19) is considered to have a diagnosis of mood and/or anxiety disorders in either time period when he/she meets at least one of the following criteria: At least one hospitalization with any of the following diagnoses over four years: depressive disorder, affective psychoses, neurotic depression or adjustment reaction, anxiety state, phobic disorders, or obsessive-compulsive disorders; At least one hospitalization with a diagnosis of anxiety disorders AND one or more prescriptions for an antidepressant or mood stabilizer over four years; At least one physician visit with a diagnosis of depressive disorder or affective psychoses over four years; At least one physician visit with a diagnosis of anxiety disorders AND one or more prescriptions for an antidepressant or mood stabilizer over four years; or Three or more physician visits with a diagnosis of anxiety disorders or adjustment reaction over four years.

<sup>r</sup> 4-year prevalence were calculated which refers to any diagnosis over a 4-year period (either 2005/06-2008/09 or 2009/10-2012/13). With the exception of developmental disorders and ASD for which a lifetime prevalence (from child's birth to the age at the end of the study period [2012/13]) is calculated.

**Figure 6.165 Per cent of children and youth ages 13 to 19 diagnosed with a mood/anxiety disorder, Manitoba, 2005/06-2008/09 and 2009/10-2012/13**



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, Burchill C, Hu M, Rajotte L, Kulbaba C. The Mental Health of Manitoba's Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. Retrieved on August 19th 2017 from: [http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf)

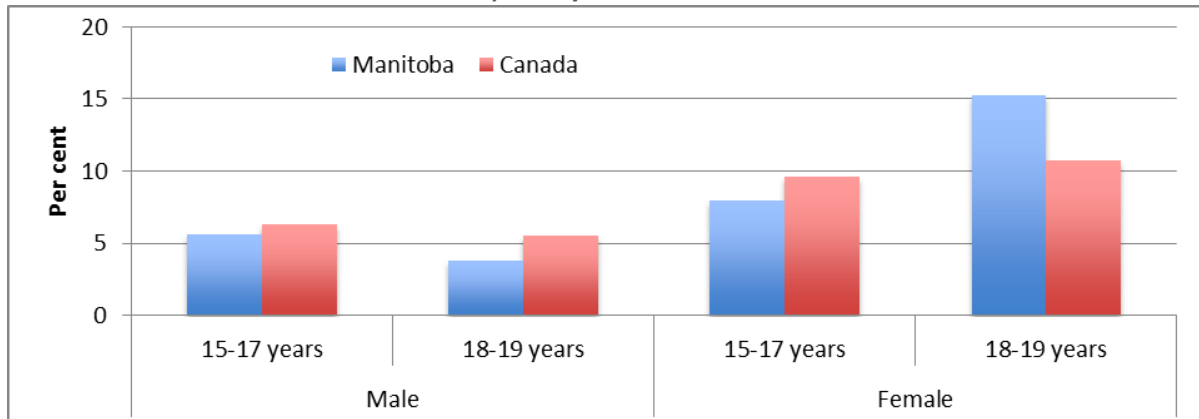
The prevalence was highest in Winnipeg and lowest in the Northern Region. In 2005/06 to 2008/09, 8,982 youth ages 13 to 19 were diagnosed for the first time with a mood/anxiety disorder. This rose to 10,976 in 2009/10 to 2012/13. The prevalence was higher among female youth ages 6 to 19 than it was among males. Southern Health/Santé Sud had a lower prevalence than the province overall. Winnipeg RHA, Prairie Mountain Health, Interlake-Eastern, and Northern saw increases in the prevalence over time.<sup>143</sup>

### 6.2.3.2 Anxiety disorder

The Canadian Community Health Survey collected self-reported information from respondents about mental health problems. For anxiety disorder, respondents were asked if they have ever received a physician diagnosis of an anxiety disorder such as a phobia, obsessive-compulsive disorder or a panic disorder.

In 2013/14, 6% of Manitoba boys aged 15 to 17 and 4% aged 18 to 19 years reported they had been diagnosed with an anxiety disorder. These were slightly lower for both age groups than Canada overall (6.3% and 6.0%, respectively). Rates of diagnosed anxiety disorder were higher for girls than boys, both in Manitoba and in Canada overall: the rate for Manitoba girls aged 18 to 19 years was almost 5 times greater than that of boys in Manitoba. Furthermore, for Manitoba girls aged 18 to 19 years, the rate was also higher (15%) than for Canada overall (11%) (Figure 6.166).

**Figure 6.166 Per cent of youth ages 15 to 17 and 18 to 19 who reported they have been diagnosed with anxiety disorder by a physician, by gender, Manitoba and Canada, 2013/14**



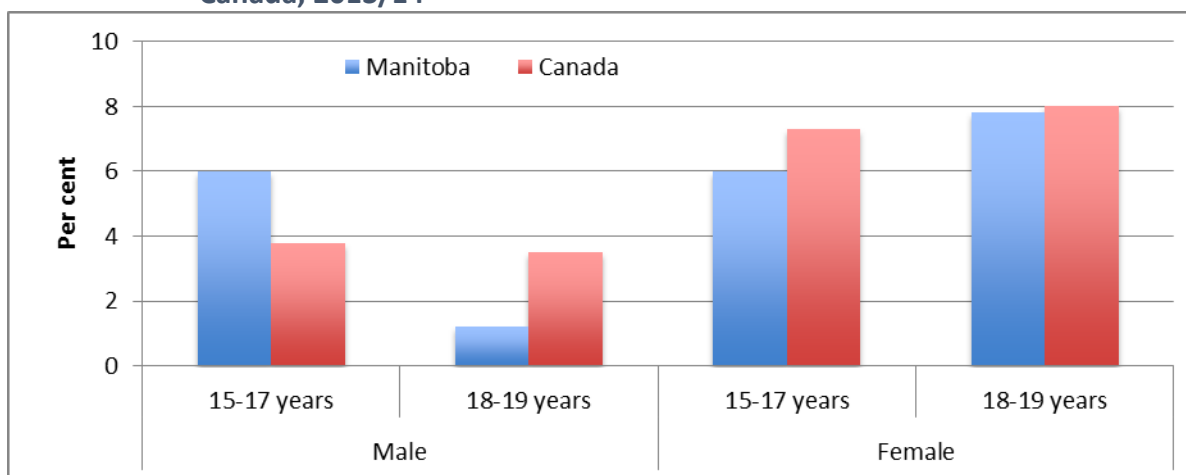
Source: Canadian Community Health Survey 2013/2014, Public Use Data Set, Accessed through ODESI on September 23rd, 2017. The Canadian Community Health Survey does not include families living in First Nations Communities.

From 2011/2012 to 2013/2014, rates of diagnosed anxiety disorders increased slightly for boys and girls ages 15 to 19 in Canada overall; Manitoba boys also saw a slight increase. For Manitoba girls ages 15 to 17, the rate went down slightly but increased from 12% to 15% for the 18 to 19 age group.<sup>25</sup>

### 6.2.3.3 Mood disorder

The Canadian Community Health Survey asked respondents if they have ever received a physician diagnosis of a mood disorder such as depression, bipolar disorder, mania or dysthymia. In 2013/14, 6% of Manitoba boys ages 15 to 17 and 1% ages 18 to 19 reported they had been diagnosed with a mood disorder. The Canada rate was lower for boys ages 15 to 17 (4%) and higher for boys ages 18 to 19 (4%). For girls age 18 to 19, rates of diagnosed mood disorders were similar to the Canadian rate overall (Figure 6.167).

**Figure 6.167 Per cent of youth aged 15 to 17 and 18 to 19 years who reported they have been diagnosed with a mood disorder by a physician, by gender, Manitoba and Canada, 2013/14**



Source: Canadian Community Health Survey 2013/2014, Public Use Data Set, Accessed through ODESI on September 23rd, 2017. Note: The Canadian Community Health Survey does not include families living in First Nations Communities.

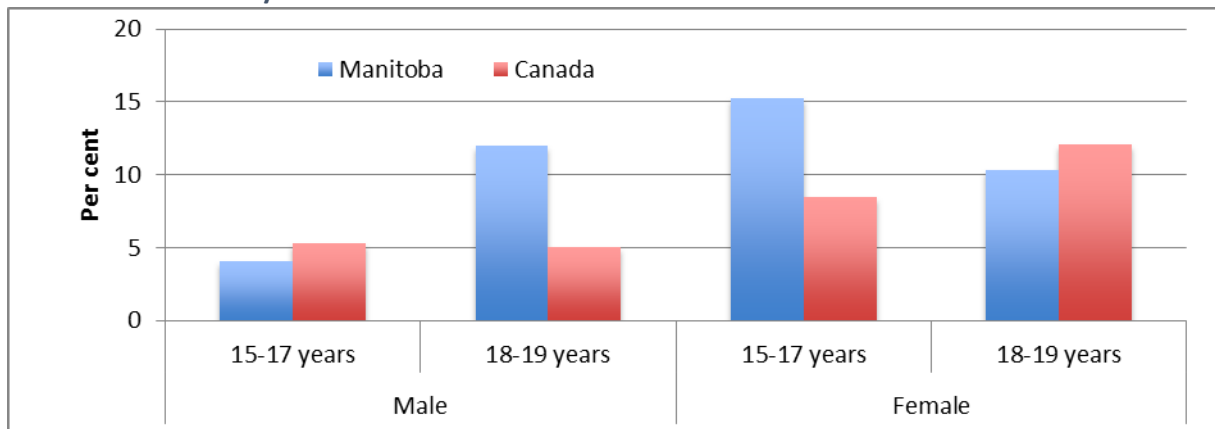
From 2011/12 to 2013/14, rates of diagnosed mood disorders increased slightly for boys age 15 to 19 in Manitoba and Canada overall. For Manitoba girls age 15 to 17, the rate stayed the same but decreased for the 18 to 19 age group in Manitoba and Canada overall. For 18- to 19-year-old girls, Canada overall saw the biggest decrease from 12% in 2011/12 to 8% in 2013/14.<sup>261</sup>

#### 6.2.3.4 Depression

In 2013/14, 4% of Manitoba boys and 15% of Manitoba girls age 15 to 17 reported that they had had major depressive episodes, close to 4 times greater for girls than boys. For this age group, the Canadian overall rate compared with the Manitoba rate was similar for boys (5.3%) but lower for girls at 9% (Figure 6.168).

For 18- to 19-year-old Manitoba boys the rate of reported depressive episodes was higher (12%) than it was for girls of the same age (10%). Compared to the Canadian rate overall, the rate of self-reported depressive episodes in Manitoba boys was more than double that of Canada overall (12% vs 5%). For Manitoba girls, the rate (10%) was lower than the Canadian rate overall (12%) (Figure 6.168).

**Figure 6.168 Per cent of youth ages 15 to 17 and 18 to 19 with 90% predictive probability of major depressive episodes\* in the past year, by gender, Manitoba and Canada, 2013/14**



Source: Canadian Community Health Survey 2013/2014, Public Use Data Set, Accessed through ODESI on September 23rd, 2017.

Note: The Canadian Community Health Survey does not include families living in First Nations Communities.

\*The Composite International Diagnostic Interview Short Form (CIDI-SF) measures Major Depressive Episodes (MDE). This subset of questions assesses the depressive symptoms of respondents who felt depressed or lost interest in things for 2 weeks or more in the last 12 months. Respondents are screened into the CIDI-SF based on affirmative responses to 2 screening questions. If a respondent answers affirmatively to the screening questions, their depression level is measured based on 7 additional questions.

The classification of depression is based on an affirmative response to the original screening question and 5 out of 9 of the depression questions. This corresponds to a 90% predictive probability of caseness, which closely aligns with the DSM-5 diagnostic guidelines for MDE in adults (American Psychiatric Association, 2013). This probability expresses the chance that the respondent would have been diagnosed as having experienced a Major Depressive Episode in the past 12 months had they completed the CIDI Long-Form (Statistics Canada, 2015). American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub.

## 6.2.4 Suicide

### 6.2.4.1 Suicide rate

In Manitoba, suicide is the leading cause of injury deaths in children 10 and over.<sup>70</sup>

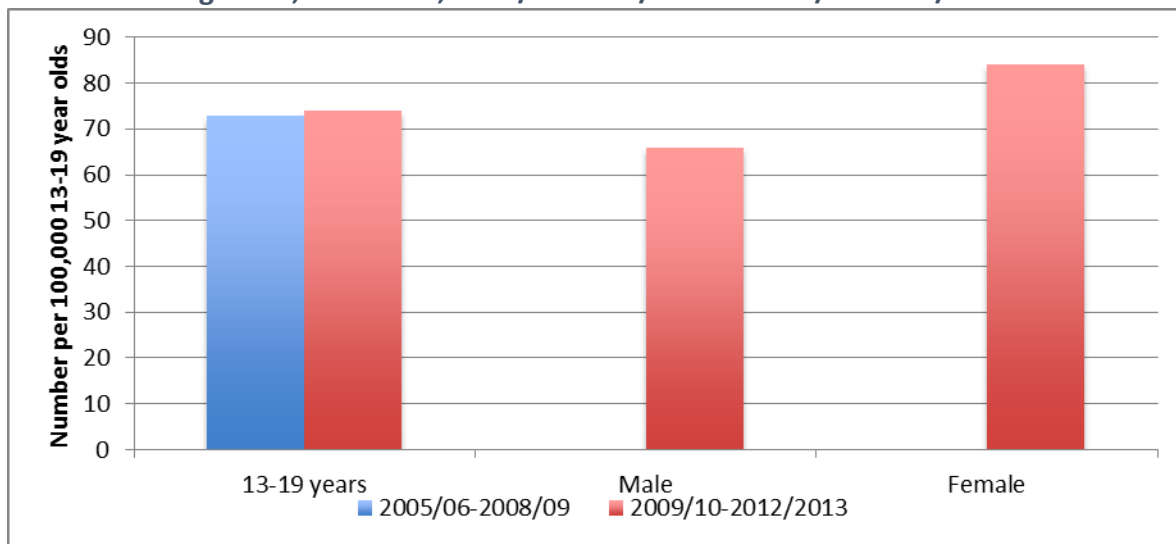
“While the majority of child deaths in Manitoba are from natural causes, each year there are preventable suicide deaths of children and youth, which not only end a young



life prematurely, but also leave in their wake a devastating impact on surviving family, friends, professionals who provided services, and more broadly, a society that shines a little less brightly for losing one of its young lights. While the numbers of suicide deaths may be relatively small each year, suicide deaths of children and youth sadden us all as they can sometimes be the outcome of significant and unresolved trauma in the life of a young person.”<sup>262</sup>

According to a recent report from the Manitoba Centre for Health Policy, the rate of suicide completion for youth ages 13 to 19 in Manitoba was 74 per 100,000 in 2009/10-2012/13. This was unchanged from the 2005/06-2008/09 rate. In 2009/10-2012/13 the suicide completion rate for 13- to 19-year-old Manitoba girls was higher (84 per 100,000) compared to the rate for Manitoba boys the same age (66 per 100,000) (Figure 6.169).

**Figure 6.169 Suicide rate (number per 100,000) among youth ages 13 to 19, by age and gender, Manitoba, 2005/06-2008/09 and 2009/10-2012/13**



Source: Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, Ekuma O, et al. The Mental Health of Manitoba’s Children. Winnipeg, MB. Manitoba Centre for Health Policy, Fall 2016. Retrieved August 19, 2017 from: [http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids\\_web\\_report.pdf](http://mchp-appserv.cpe.umanitoba.ca/reference/MHKids_web_report.pdf)  
 Note: Suicide is the act of intentionally killing oneself. In this study, MCHP defined suicide among adolescents (aged 13-19) in both time periods using death records in Vital Statistics data that list self-inflicted injury or poisoning as the primary cause of death. Suicide and rates were calculated as the rate per 100,000 adolescents (rather than percentages) because of the small numbers of individuals in this cohort.

In 2014, the Office of the Children’s Advocate began a project examining youth suicide in Manitoba. They investigated risk factors that were present in the lives of 50 youth who died by suicide in Manitoba between January 1, 2009, and December 31, 2013. These youth had been receiving child welfare services at the time of their death or had received such services in the year prior to their death. This study found that a greater proportion of females die by suicide, at an increasingly young age, and hanging was found to be the dominant method by which youth are dying by suicide. Major themes consistent between the 50 youth who died included inconsistent attendance at school, previous hospitalization for suspicious injuries, involvement with the criminal justice system, documented suicidal ideation, parental and youth substance abuse, and frequent placement moves.<sup>262</sup>

Among Manitoba First Nations youth ages 15 to 24, suicide rates are 5 times the national average for males and 7 times for females. First Nations youth attempt suicide approximately 5

times more often than non-First Nations youth.<sup>70</sup> The Manitoba Regional Health Survey<sup>263</sup> found that almost 1 in 5 youth (ages 12 to 17) in First Nations communities had contemplated suicide, and 10% had attempted at least once.

It is important to note that Indigenous youth suicide rates differ significantly between communities. Studies in British Columbia have shown that suicide rates are much lower in communities in which at least half the band members report a conversational knowledge of their native language, communities with self-government, and communities with control over their land, schools, and services such as health care.<sup>199,264</sup>

#### *6.2.4.2 Attempted suicide*

The Manitoba Centre for Health Policy reported that 459 per 100,000 Manitoba youth ages 13 to 19 attempted suicide<sup>5</sup> in the four-year period 2009/10 to 2012/13 compared to 424 per 100,000 youth attempted suicides in 2005/06 to 2008/09.<sup>143</sup> In 2009/10 to 2012/13, more than 3 times as many 13- to 19-year-old Manitoba girls (729) attempted suicide than Manitoba boys the same age.

The rate of attempted suicide was higher in rural/northern areas compared to urban areas. Suicide and attempted suicide were more prevalent in low-income areas than in higher-income areas. Among those who had attempted suicide or died by suicide, 78% had a diagnosis of a mental disorder during the same time period.<sup>143</sup>

A recent study in Ontario, Manitoba, Alberta and British Columbia found that young people had the highest rates of suicide attempts, especially between ages 15 and 19. The rates in Manitoba were the highest, with about 18 attempts per 1,000 teens in that age group who suffered from mental illness or addiction. The rate for both British Columbia and Alberta were around 10 attempts per 1,000 teens.<sup>265</sup>

#### *6.2.4.3 Suicidal thoughts*

According to the 2012 Aboriginal Peoples Survey,<sup>151</sup> 18% of Manitoba First Nations youth and 10% of Manitoba Métis youth age 18 to 24 years reported they had seriously considered suicide. The Canadian overall rate was lower for First Nations youth (16%) and higher for Métis youth (15%).

### **6.3 Safe and Secure**

#### **6.3.1 Safety**

##### *6.3.1.1 Physical risks: Injury and mortality*

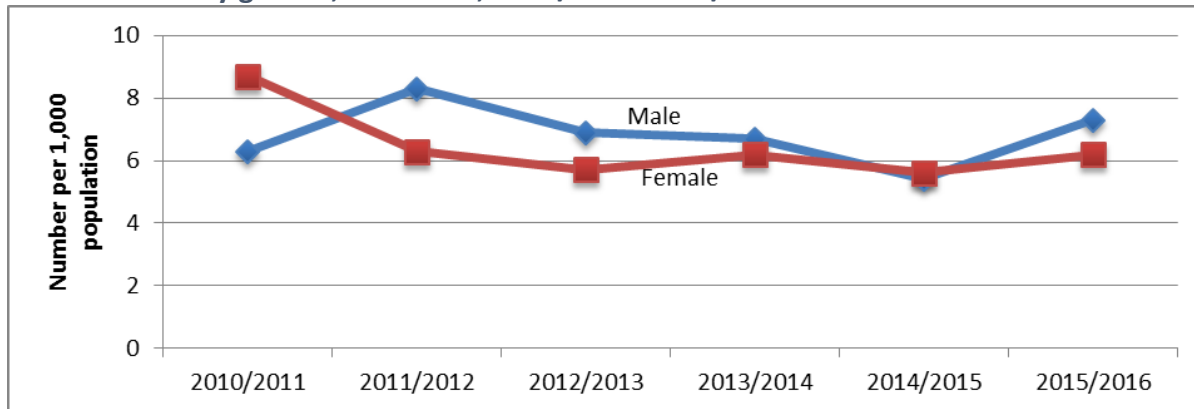
Injuries are the most common cause of hospitalization, following pregnancy, for youth in Manitoba.<sup>131</sup> Research has shown that injuries can have long-term effects on youth functioning and quality of life.<sup>266</sup> In 2015/16, the injury hospitalization rate for young men aged 15 to 19

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<sup>5</sup> In the MCHP study, an attempted suicide is defined by any hospitalization for self-inflicted injury, or for accidental poisoning where the poisoning is followed by a consult to psychiatry. It was not possible to distinguish self-harm from attempted suicide in this indicator. An adolescent (aged 13-19) is considered to have attempted suicide in either time period if they were hospitalized for the reasons described above.

years was 7.3 per 1,000 population. It was higher than the 6.2 per 1,000 rate for young women. The rates for both young men and women declined between 2010/11 and 2015/16, but the decline was greater for young women (Figure 6.170).

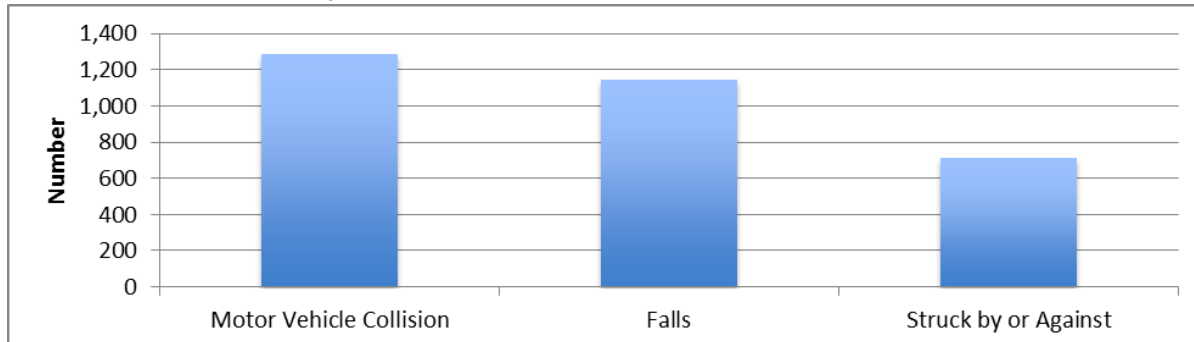
**Figure 6.170 Rate of injury hospitalization, youth aged 15 to 19 years (per 1,000 population), by gender, Manitoba, 2010/11 to 2015/16**



Source: Manitoba Health, Seniors and Active Living Annual Statistics 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015. Retrieved from <http://www.gov.mb.ca/health/annstats/>

The leading cause of unintentional injury hospitalizations among youth aged 15 to 19 for the years 2000 to 2012 was motor vehicle collisions (Figure 6.171).

**Figure 6.171 Leading causes of unintentional injury hospitalizations, youth 15 to 19 years, Manitoba, 2000 to 2012**



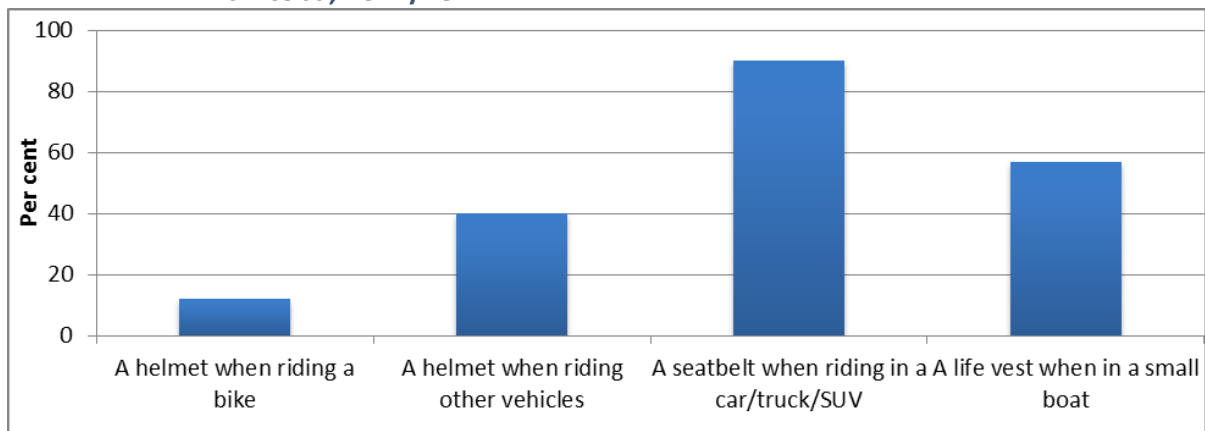
Source: Injury Prevention Plan: Taking Steps to Prevent Injuries in Manitoba, Manitoba Health, Healthy Living and Seniors, June 2015. Retrieved from [https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury\\_prevention\\_plan.pdf](https://www.gov.mb.ca/healthyliving/hlp/docs/injury/injury_prevention_plan.pdf) Accessed July 24, 2017

Note: The category "struck by or against" includes exposures such as inanimate mechanical forces by objects and a strike or bump by another person including during legal action.

In the years 2000 to 2012, the leading cause of unintentional injury death among Manitoba youth ages 15 to 19 was motor vehicle collisions, followed by poisonings and suffocation. Motor vehicle collisions claimed the lives of 173 youth 15 to 19 years of age. Poisoning caused 30 deaths, suffocation 24.

According to the Manitoba Youth Health Survey, in 2012/13, 90% of youth in Grades 9 to 12 reported that they always wore a seatbelt when riding in a car/truck/SUV. However, only 12% reported that they always wore a helmet when riding a bike (Figure 6.172).

**Figure 6.172 Per cent of youth in Grades 9 to 12 who always wear safety equipment, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

### 6.3.1.2 Crisis services

The youth crisis service system is composed of three segments: crisis phone lines, assessment services (mobile crisis service or emergency department), and crisis stabilization units.

Crisis service availability differs across regions in terms of service existence, accessibility and hours of operation. Mobile Crisis services vary by region, and services depend on geographic accessibility in some regions.

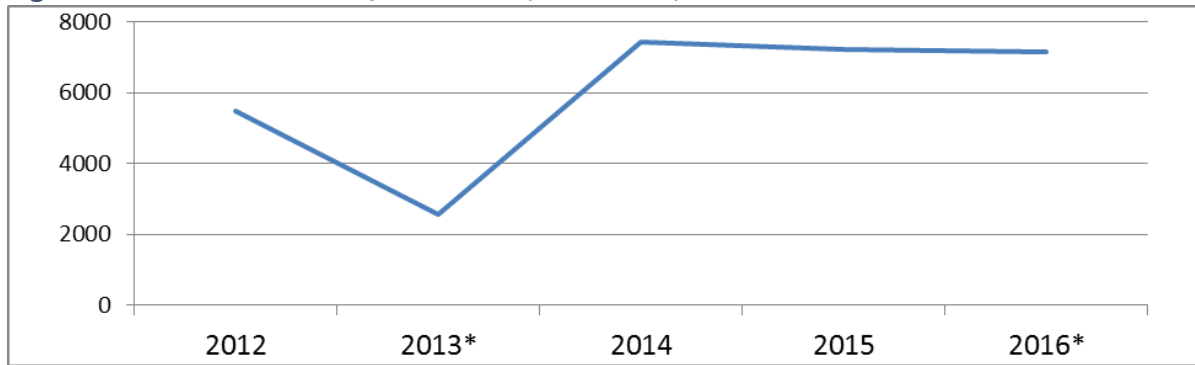
In addition to the regional crisis lines there are 24/7 provincial and national crisis lines available to Manitoban children and youth. These include:

- MacDonald Youth Services
- Manitoba Suicide Line
- Kids Help Phone
- First Nations and Inuit Hope for Wellness Help Line (launched on October 1, 2016) and
- Clinic Crisis Line

Kids Help Phone is not specific to crisis services, so their data has not been included in the crisis service graphs below. They provide an important service to Manitobans in times of crisis though and their 2016 report stated that Manitobans had 1100 contacts with counselling involved.

Figure 6.173 presents the provincial use of crisis phone lines and mobile/assessment services. Please note: The data is influenced by an underrepresentation of service requests in areas with limited or no service, and differences in data tracking and categorization.

**Figure 6.173 Mobile Crisis/ Crisis Calls, Manitoba, 2012 to 2016**

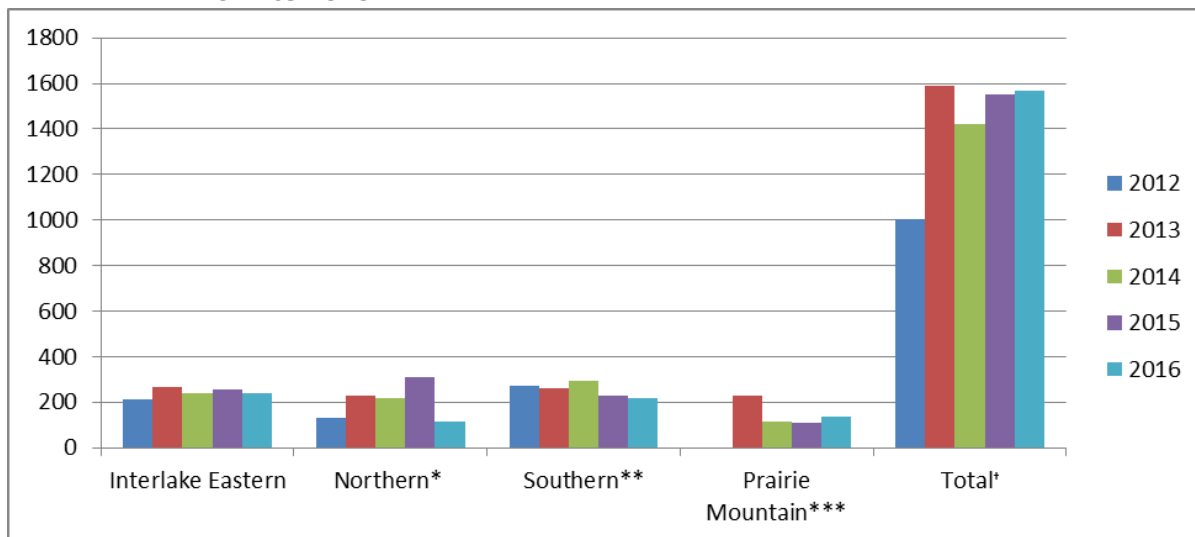


Source: Data compiled by Mental Health and Addictions Branch, Manitoba Health, Seniors & Active Living.

\* Note that call data for 2013 is incomplete.

Figures 6.174 and 6.175 present the provincial use of crisis phone lines and mobile/assessment services by region. The Northern Health Region is seeing an increase in service utilization while the Winnipeg and Interlake-Eastern Health regions have maintained steady levels, and Southern Health and Prairie Mountain Health have a slight reduction in service utilization.

**Figure 6.174 Number of mobile crisis/crisis calls by region (excluding Winnipeg), Manitoba, 2012 to 2016**



Source: Data compiled by Mental Health and Addictions Branch, Manitoba Health, Seniors & Active Living.

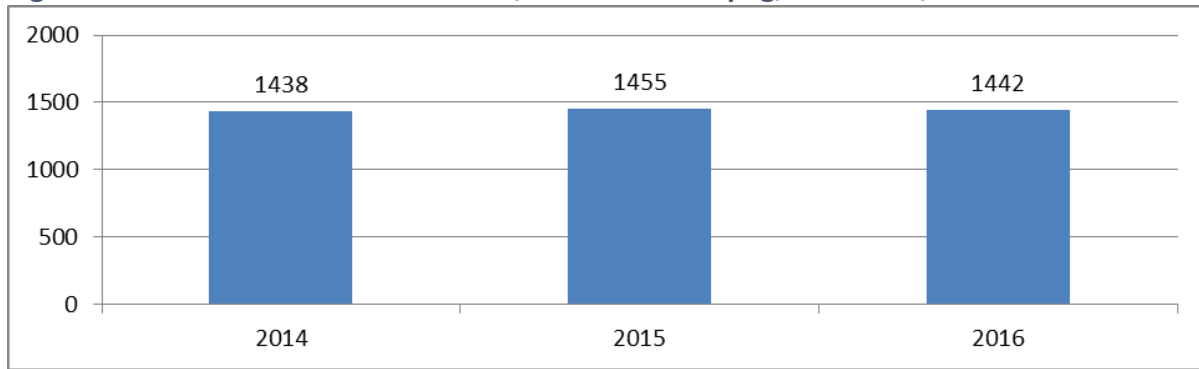
\*2016 data is partial (4 months of data only)

\*\*The data reflects phone calls and call outs to provide crisis assessments at Emergency Departments after hours.

\*\*\*Excludes intake crisis work and urgent mental health assessments

Note: Does not include data for Winnipeg. See below.

**Figure 6.175** Number of mobile crisis/crisis for Winnipeg, Manitoba, 2014 to 2016



Source: Data compiled by Mental Health and Addictions Branch, Manitoba Health, Seniors & Active Living.

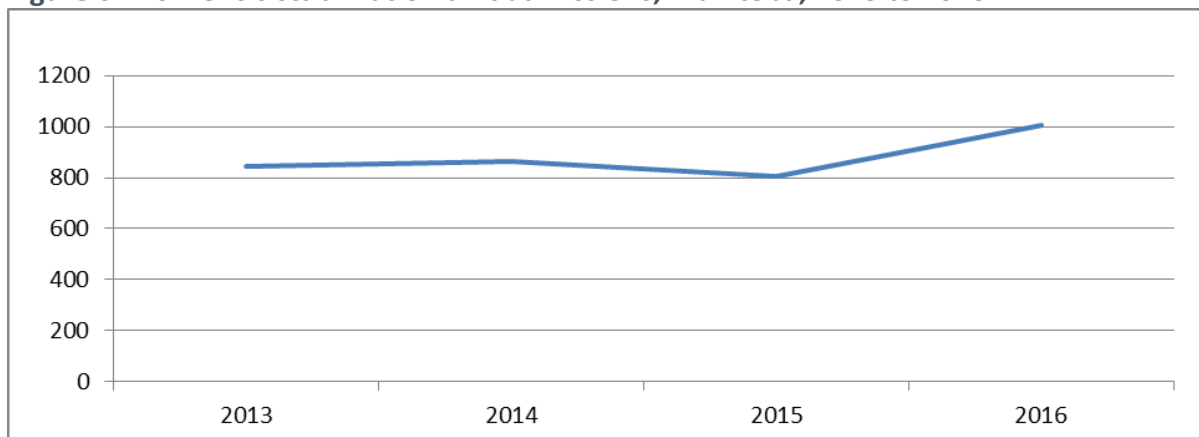
### 6.3.1.3 Emergency department utilization

Emergency departments are an important component of crisis service delivery. Winnipeg provides a centralized hospital admission point for the province. Over the past 18 years, there has been a greater than five-fold increase in the number of psychiatric consultations completed in the Children’s Hospital emergency department. Consultation requests have grown from 250 per year in 1999 to 1,350 per year in 2016 and continues to climb at a rate of approximately 10% per year. The vast majority of these youth are in crisis which reflects the dramatic increase in the crisis level among youth in the province. Of the mental health presentations at the Children’s Hospital emergency department, 16- and 17-year-olds comprise almost 50% of youth referred for emergency mental health service. This is independent of the number of youth that are seen in the emergency department that did not require psychiatric consultation.

### 6.3.1.4 Crisis stabilization units and in-patient admissions

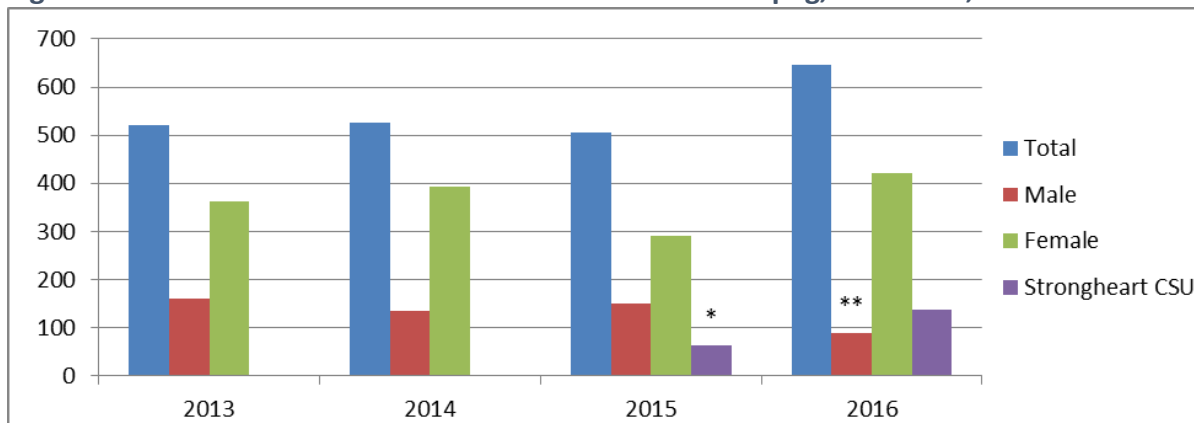
Figure 6.176 presents the provincial use of crisis stabilization units, which remained relatively stable until 2016, when there was a much higher utilization rate. Figure 6.177 presents Winnipeg-specific data by gender and the opening of the Indigenous girls’ Crisis Stabilization Unit called Strongheart.

**Figure 6.176** Crisis stabilization unit admissions, Manitoba, 2013 to 2016



Source: Data compiled by Mental Health and Addictions Branch, Manitoba Health, Seniors & Active Living.  
Note: Includes CSU data from Interlake, Prairie Mountain and Winnipeg.

**Figure 6.177 Crisis stabilization unit admissions in Winnipeg, Manitoba, 2013 to 2016**



Source: Data compiled by Mental Health and Addictions Branch, Manitoba Health, Seniors & Active Living.

\*Statistics for 2014/15 reflect use from October 1, 2014 to March 31, 2015.

\*\* Database changes at Boys' CSU; number reflects use from August 1, 2015 to April 1, 2016

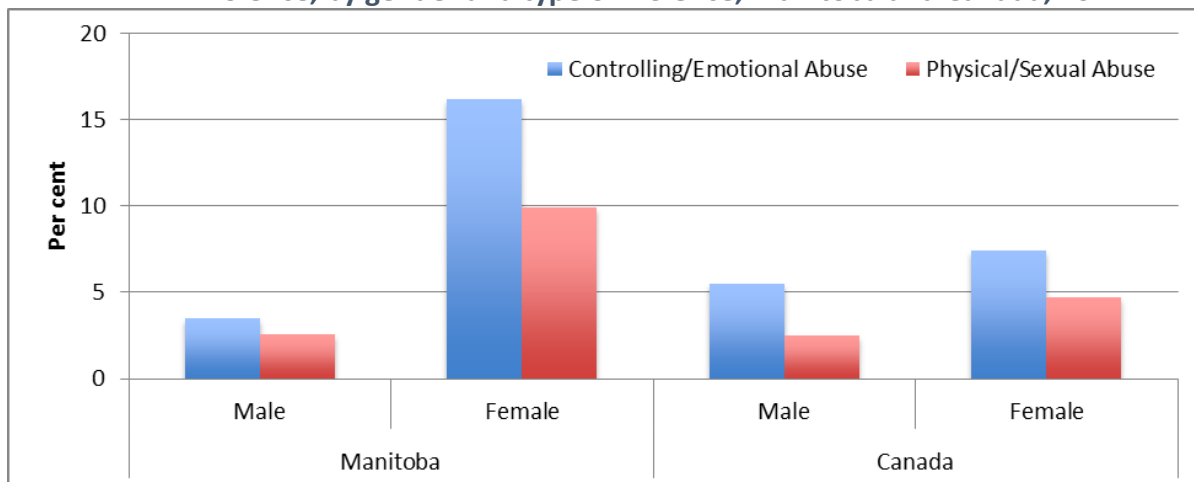
### 6.3.1.5 Safe relationships

Healthy relationships include setting healthy boundaries with the people in their lives, as well as respecting their boundaries. "Dating and/or romantic relationships can exist on a spectrum, from healthy to unhealthy and sometimes abusive. In a healthy dating relationship, all people have equal power and are involved in decision-making. We also need mutual respect and trust to maintain healthy relationships with the people in our lives. If important things like respect and trust are missing, it may be an unhealthy relationship. If there is fear, threats and/or physical, sexual, financial, emotional/mental or spiritual abuse happening, then it often is an abusive relationship."<sup>267</sup>

According to the 2014 General Social Survey regarding dating violence, 4% of Manitoba males age 15 to 24 reported being victims of controlling/emotional abuse in a relationship, and 3% reported experiences of physical/sexual abuse. The Canadian rate overall for males age 15 to 24 was slightly higher at 6% for controlling/emotional abuse and the same for physical/sexual abuse as it was for Manitoba males (Figure 6.178).

Females in Manitoba and Canada overall reported much higher rates of dating violence. In Manitoba, 16% of young women 15 to 24 years of age reported experiencing controlling/emotional abuse. This was more than double the Canadian overall rate for females ages 15 to 24 (7%). The proportion of Manitoba young women age 15 to 24 who experienced physical/sexual violence was 10%, also double the Canadian overall rate (5%) (Figure 6.178).

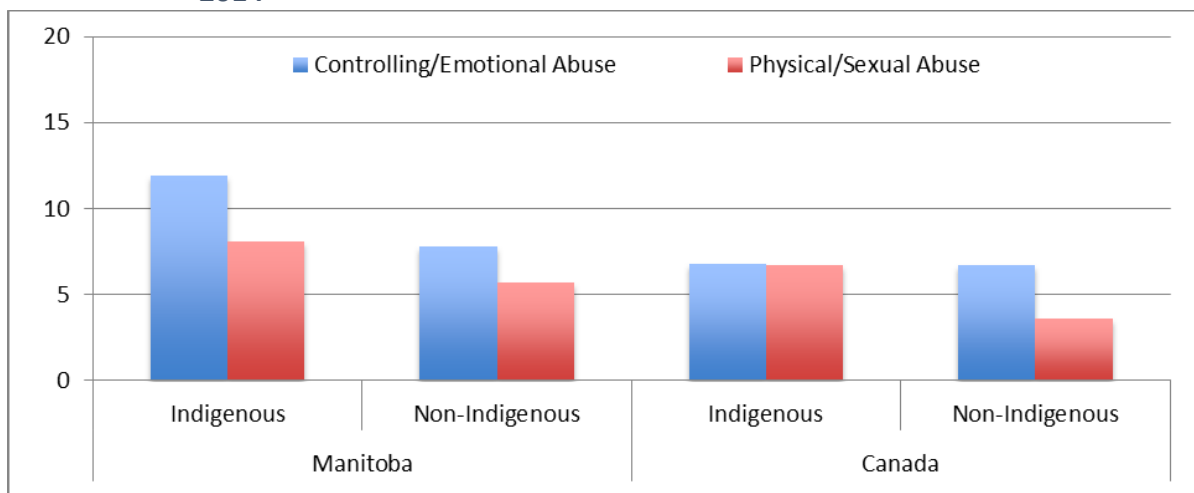
**Figure 6.178 Per cent of 15- to 24-year-olds reporting that they have been victims of dating violence, by gender and type of violence, Manitoba and Canada, 2014**



Source: Statistics Canada, 2016. General Social Survey, Cycle 28, 2014: Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

According to the 2014 General Social Survey, 12% of Indigenous youth age 15 to 24 reported being victims of controlling/emotional abuse in a relationship, higher than non-Indigenous youth at 8%. Experiences of physical/sexual abuse in a relationship were reported by 8% of Indigenous and 6% for Non-Indigenous Manitoba youth aged 15 to 24. Both Manitoba Indigenous and Non-Indigenous youth age 15 to 24 reported higher rates of controlling/emotional abuse and physical/sexual abuse than Canada overall (Figure 6.179).

**Figure 6.179 Per cent of 15- to 24-year-olds reporting that they have been victims of dating violence, by Indigenous identity, and type of violence, Manitoba and Canada, 2014**



Source: Statistics Canada, 2016. General Social Survey, Cycle 28, 2014: Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

### *Violence against youth*

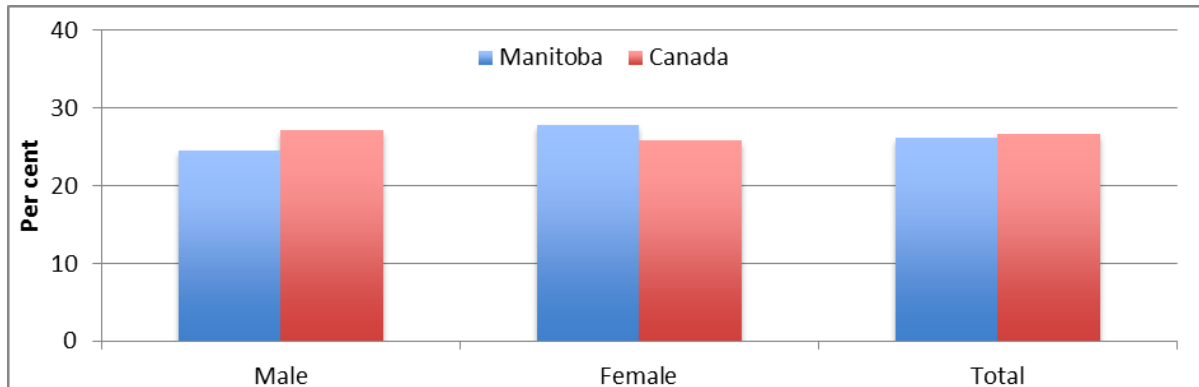
In Canada, the most common types of violent crimes experienced by children and youth under 18 years of age are physical assaults (boys are more likely to be victims) and sexual assaults (the vast majority of victims are female). Child and youth victims of violence experience not only



immediate physical and emotional consequences, but also long-term consequences, including increased risk of behavioural and emotional disorders. These include aggressive, self-destructive, or delinquent behaviour, as well as depression, fear or anxiety.<sup>268</sup>

In 2014, 26% of Manitoba youth aged 15 to 24 reported that they had been a victim of a crime. That proportion was similar to Canada overall at 27%. In Manitoba, 28% of young women reported having been victims, as did 25% of young men (Figure 6.180).

**Figure 6.180 Per cent of youth ages 15 to 24 who reported that they were a victim of a crime (excluding spousal or dating violence), by gender, Manitoba and Canada, 2014**

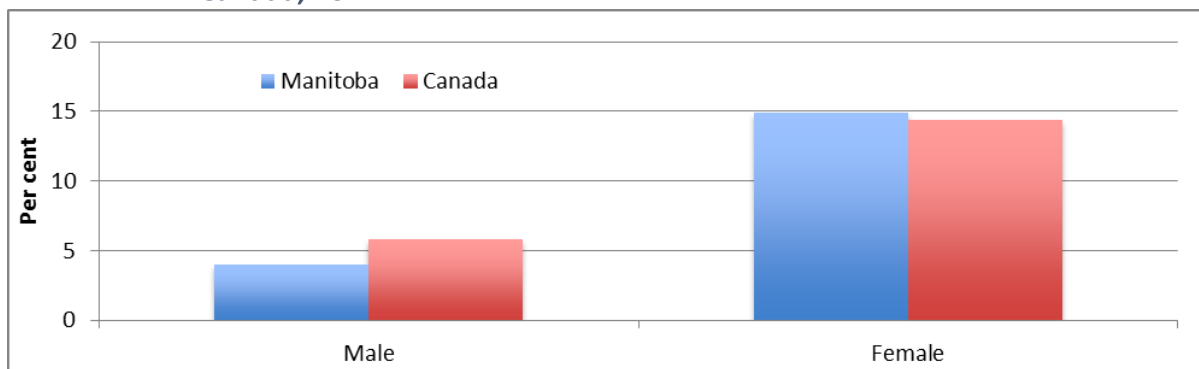


Source: General Social Survey, Cycle 28, 2014 [Canada]: Victimization, Main File

### *Neighbourhood safety*

In Manitoba, in 2014, 15% of females age 15 to 24 years reported feeling very unsafe or somewhat unsafe from crime walking alone in their area after dark, compared to 4% for Manitoba males the same age (Figure 6.181).

**Figure 6.181 Per cent of youth ages 15 to 24 who feel very unsafe or somewhat unsafe in their neighbourhood walking alone after dark, by gender, Manitoba and Canada, 2014**



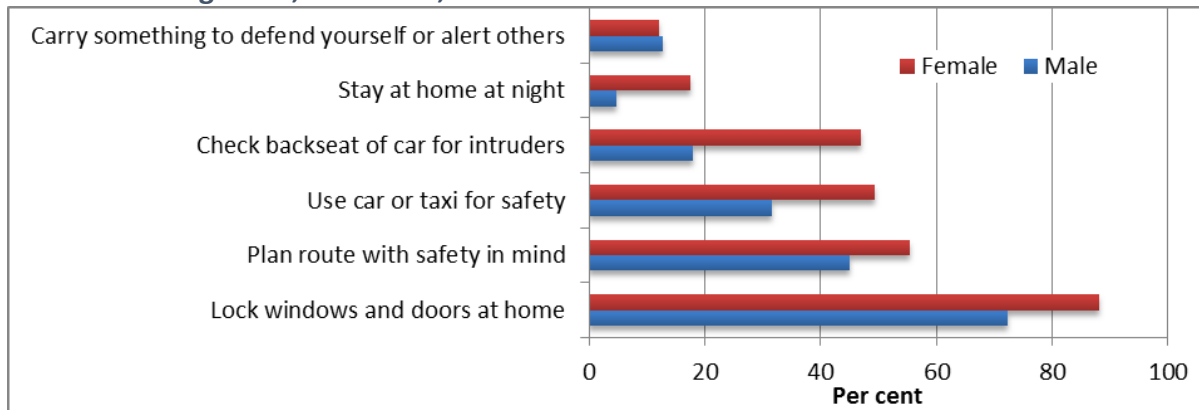
Source: Statistics Canada. 2016. General Social Survey, Cycle 28, 2014 : Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

### *Safety behaviours*

The 2014 General Social Survey asked young people about safety behaviours that they engaged in to protect themselves from crime. The most frequently used safety behaviour among young

Manitoba women age 15 to 24 was locking the doors or windows at home (88%). This was followed by planning a route with safety in mind (56%), using a car or taxi (49%) and checking the car for the backseat of car for intruders (47%). Young men were less likely to engage in all safety behaviours, except for carrying something to defend themselves or alert others (Figure 6.182).

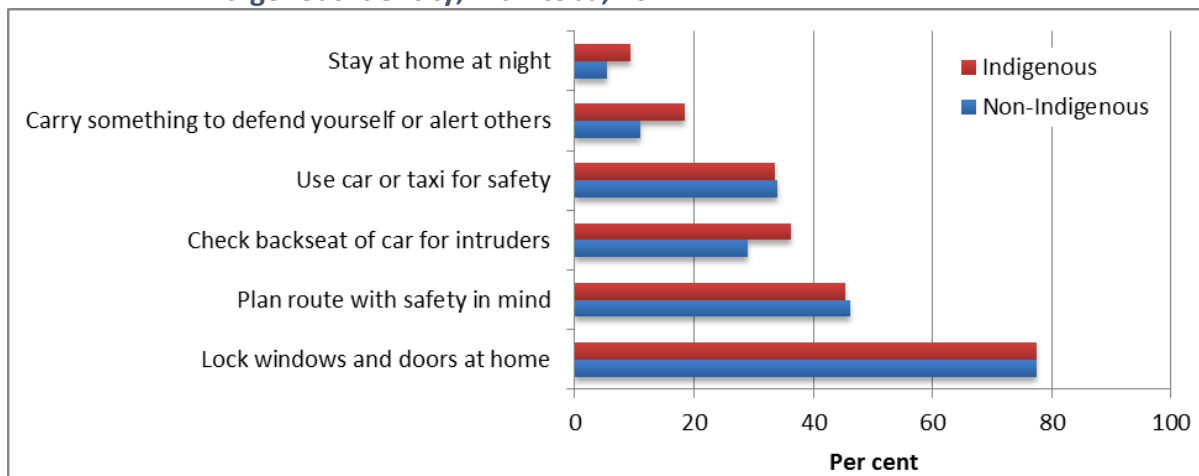
**Figure 6.182 Per cent of youth ages 15 to 24 engaging in specific safety behaviours, by gender, Manitoba, 2014**



Source: Statistics Canada, 2016. General Social Survey, Cycle 28, 2014: Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

Manitoba Indigenous youth and non-Indigenous youth engage in similar safety behaviours (Figure 6.183).

**Figure 6.183 Per cent of youth ages 15 to 24 engaging in specific safety behaviours, by Indigenous identity, Manitoba, 2014**



Source: Statistics Canada. 2016. General Social Survey, Cycle 28, 2014: Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

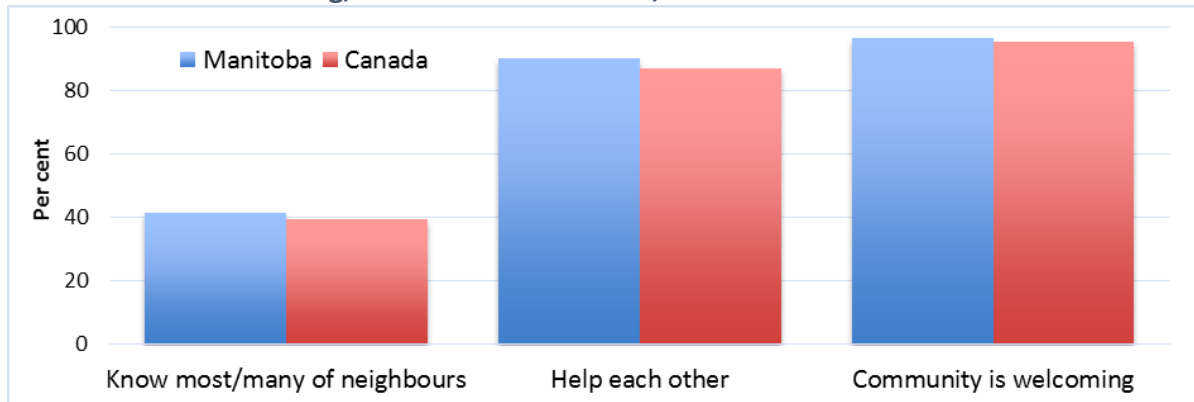
### *Neighbourhood cohesion*

Neighbourhoods are an important part of the lives of youth. Cohesive neighbourhoods can help young people develop a sense of belonging, perceive their communities as safe, create connections within the community, and lead to increased social capital.<sup>269,270</sup>

The majority of 15- to 24-year-old youth in Manitoba report that their communities are cohesive: 90% reported that people in their community help each other and 96% reported that

their community is welcoming. Fewer (42%) reported that they actually knew many or most of their neighbours. These proportions are similar to those in Canada overall (Figure 6.184).

**Figure 6.184 Per cent of youth ages 15 to 24 who report that they know most/many of their neighbours, help each other in their community and that their community is welcoming, Manitoba and Canada, 2014**



Source: General Social Survey, Cycle 28, 2014 [Canada]: Victimization, Main File

Young women are more likely to know most of their neighbours in Manitoba (46%) compared to young men (37%). Similar proportions of young women and men report that their community is helpful and welcoming in Manitoba.

Almost all Indigenous youth in Manitoba (99%) reported that their neighbourhood was welcoming compared to 95% in Canada overall. Of Manitoba Indigenous youth aged 15 to 24 years, 74% reported that people help each other in their neighbourhood, compared to 83% in Canada overall. Of Indigenous youth aged 15 to 24 years in both Manitoba and Canada overall, 50% reported that they knew most or many of their neighbours.<sup>271</sup>

### 6.3.1.6 Safe families

Youth spend most of their time with their peers, and less time with their families than when they were younger. However, a safe family environment continues to be an important determinant of their well-being. Secure attachment between parents and youth is an important factor in supporting the transition to adulthood and ensuring healthy development. Secure parental attachments are associated with positive outcomes, including better mental health.<sup>272,273</sup> Unfortunately, many youth face safety and security concerns within their own families.

In 2015, there were about 38,400 youth victims (12 to 17 years) of police-reported violent crime in Canada. Among these youth victims, approximately 7,700 (20%) were victims of family violence perpetrated by a parent, sibling, extended family member or spouse. Of those 7,700 who were victims of family violence, 64% were females and 36% were males.<sup>113</sup>

Youth between 12 and 17 years of age have the highest rates of police-reported family violence of all children and youth. In 2015, in Canada, of all children and youth under 18 who are victims of family violence, youth aged 12 to 17 accounted for 48% of them. The age at which both male and female children and youth were most often victimized was age 15. Female youth between

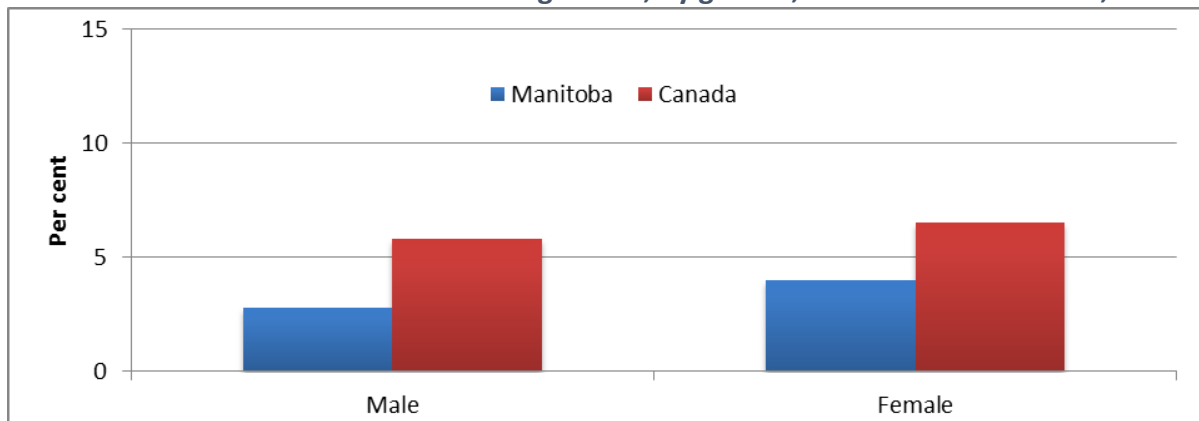
14 and 16 years of age were twice as likely as their male counterparts to be victimized by a family member.<sup>113</sup>

Youth aged 12 to 17 were victimized by a parent in 48% of cases, an extended family member in 27% of cases, a sibling in 20% of cases, and a spouse (16 and 17 years old) in 5%.<sup>113</sup>

### Witnessing family violence

The 2014 General Social Survey asked the following question to help better understand family violence: “Before the age of 15, did you see or hear any one or your parents, step-parents or guardians hit each other or another adult at least once?” The survey found that 3% of Manitoba young men and 4% of Manitoba young women age 15 to 24 responded yes to this question. This was less than for Canada overall where 6% of men and 7% of women answered yes (Figure 6.185).

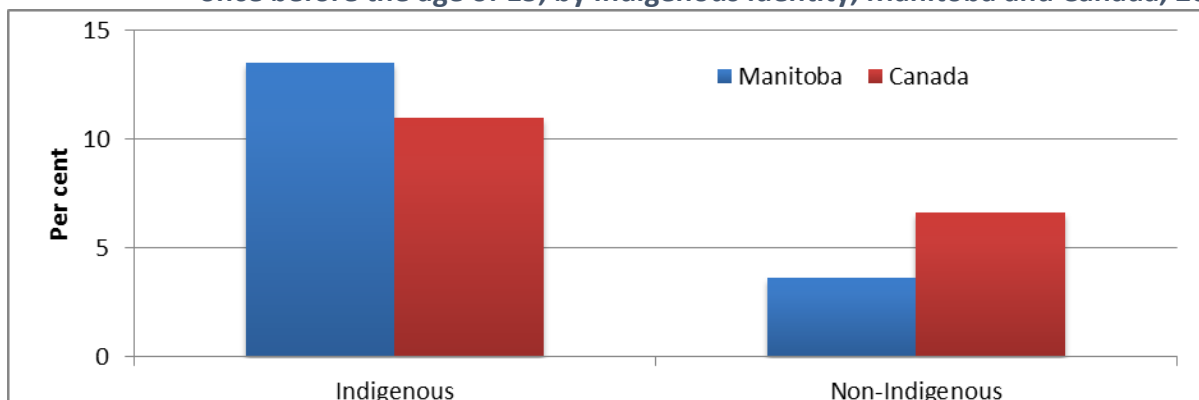
**Figure 6.185** Per cent of Manitoba youth aged 15 to 24 who have witnessed family violence at least once before the age of 15, by gender, Manitoba and Canada, 2014



Source: Statistics Canada. 2016. General Social Survey, Cycle 28, 2014: Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

Of Manitoba’s Indigenous youth (15 to 24 years), 14% reported that they had witnessed family violence before the age of 15, compared to 4% of non-Indigenous youth (Figure 6.186).

**Figure 6.186** Per cent of youth ages 15 to 24 who have witnessed family violence at least once before the age of 15, by Indigenous identity, Manitoba and Canada, 2014



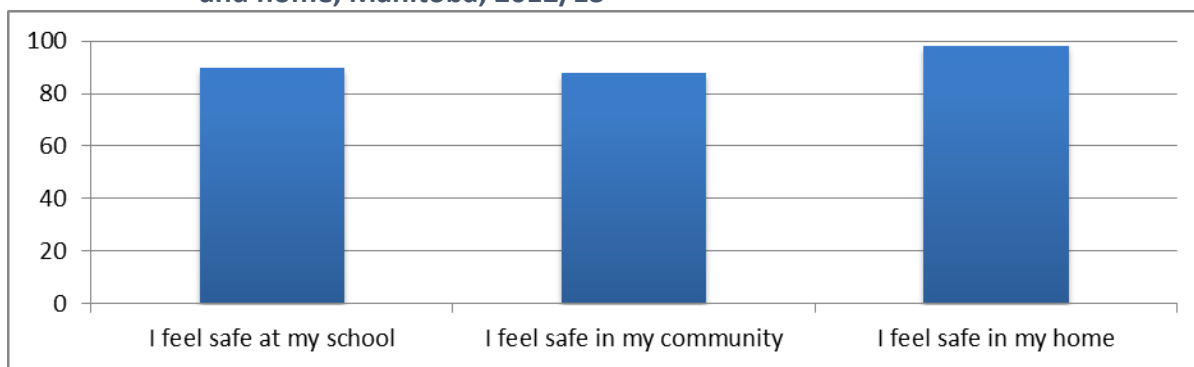
Source: Statistics Canada, 2016. General Social Survey, Cycle 28, 2014: Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

### 6.3.1.7 Safe schools and communities

Keeping schools and communities safe is an important priority and a key factor in helping adolescents mature without the negative effects of bullying or violence. Adolescents may bully or harass their peers for a number of reasons, including physical appearance, race/ ethnicity, or sexual orientation. Feeling safe at school has been linked to better physical and emotional health, as well as a reduced likelihood of risk taking.<sup>274</sup> Over 80% of youth in Manitoba report feeling safe at school, home and in their communities (Figure 6.187).

According to the Manitoba Youth Health Survey, in 2012/2013, the majority of Manitoba students in Grades 9 to 12 reported that they felt safe in their school (90%), their community (88%) and in their home (98%) (Figure 6.187).

**Figure 6.187 Per cent of students in Grades 9 to 12 who feel safe in their school, community and home, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

### *Supporting transgender and gender diverse youth in Manitoba schools*

Two recent studies in Manitoba have identified that transgender and gender diverse students often experience school as unsafe environments where they face transphobic harassment, rejection, discrimination and even violence both from other students and staff.<sup>243,244</sup>

A national survey of over 3,700 students, conducted between December 2007 and June 2009, found that 64% of LGBT2SQ+ (lesbian, gay, bisexual, transgender, two spirit, and queer+) students and 61% of students with LGBT2SQ+ parents reported that they feel unsafe at school. Of all participating students, LGBT2SQ+ and non-LGBT2SQ+, 70% reported hearing expressions such as “that’s so gay” every day in school and almost half (48%) reported hearing remarks such as “faggot”, “lezbo” and “dyke” every day in school. Seventy-four per cent of trans students, 55% of sexual minority students, and 26% of non-LGBT2SQ+ students reported having been verbally harassed about their gender expression. 37% of trans students, 32% of female sexual minority students, and 20% of male sexual minority students reported being verbally harassed daily or weekly about their sexual orientation. One in five (21%) LGBT2SQ+ students reported being physically harassed or assaulted due to their sexual orientation.<sup>243</sup>

Manitoba is committed to creating environments where all children feel welcome and safe. In 2017, Manitoba Education and Training released the document *Supporting Transgender and Gender Diverse Students in Manitoba Schools*.<sup>245</sup>

The document is intended to support schools and school boards in fulfilling a shared responsibility to promote the dignity, respect, human rights and equity of transgender and gender diverse students. The core of the document provides guidelines to help school divisions and schools, with the involvement of students with lived experiences and their families, to develop their own policies and protocols to promote respect for and equity of trans and gender diverse students in safe, caring, and inclusive schools and learning environments.

The Canadian Trans Youth Health Survey was administered online to 923 participants across Canada, and included 67 youth from Saskatchewan and Manitoba combined. Two different surveys were distributed: one to younger (14-18 years) and the other to older (19-25 years) youth. Similar to national findings, safety, violence, and discrimination were key issues in Manitoba and Saskatchewan. Over half (53%) of younger trans youth had been bullied in school, an estimated three-quarters of both younger (76%) and older (70%) trans youth had been treated unfairly due to their gender identity, and over half of both younger (59%) and older (74%) trans youth had been treated unfairly due to their physical appearance. Over three-quarters (77%) of younger trans youth had experienced unwanted sexual comments, jokes, or gestures directed at them, nearly 2 in 5 of all trans youth (39%) had been subject to sexual assault, and over half of older youth indicated they had been cyberbullied in some way. The level of school connectedness among youth was lower than the national average. Trans youth in Manitoba and Saskatchewan had an average score of 4.4 out of 10 on the school connectedness index, compared to the national average of 4.9.<sup>244</sup>

### *Bullying*

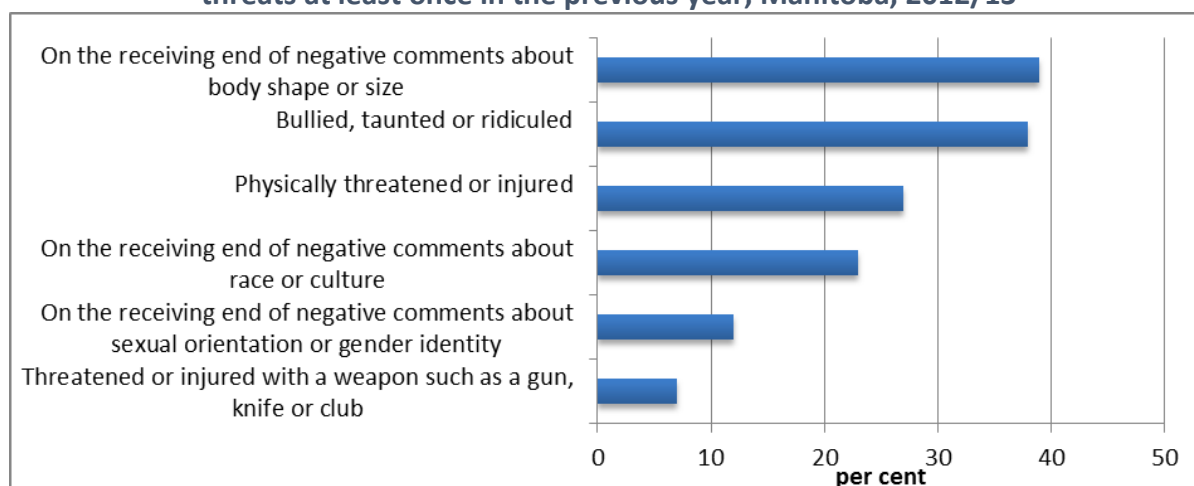
Physical and emotional bullying, either face-to-face or online (known as cyberbullying), is a very real and growing problem facing Canadian children and youth. Bullying, either being bullied or being the bully, can cause a number of social, physical and mental health problems for children and adults such as headaches, stomach problems, depression and anxiety. They are also more likely to miss school, suffer poor grades, use drugs and alcohol and be involved in criminal activity.<sup>275</sup>

If not addressed, bullying behaviours can continue and even escalate as children become aware of others' vulnerabilities and of their own power relative to others, potentially translating into the cycle of violence and abuse continuing later in life.<sup>275</sup>

Early identification and intervention that helps bullies deal with underlying issues will help prevent these patterns of aggressive interactions from forming.<sup>275</sup>

In 2012/13, 39% of Manitoba youth in Grades 9 to 12 reported that they had received negative comments about their body shape or size in the last year and another 38% had been bullied, taunted or ridiculed. More than one-quarter (27%) had been physically threatened or injured and 23% had been on the receiving end of negative comments about race or culture (Figure 6.188).

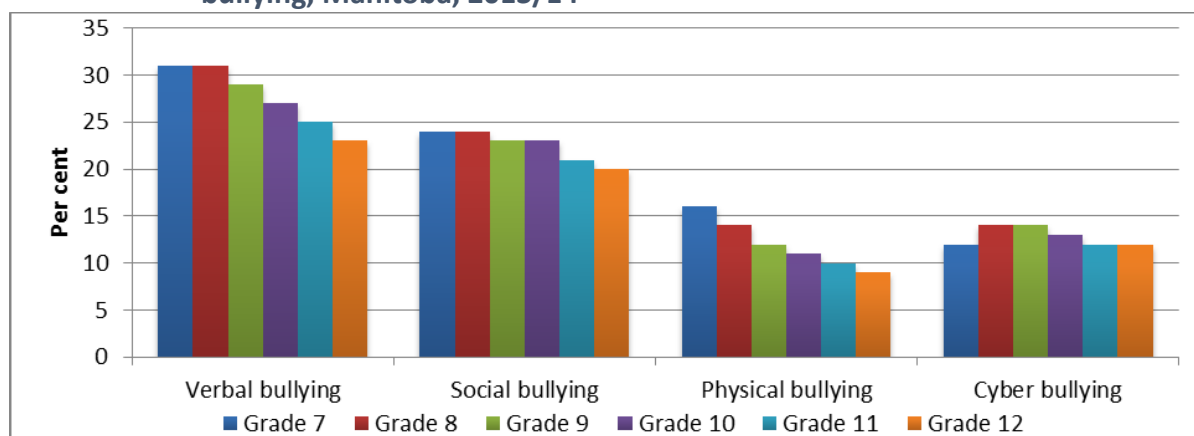
**Figure 6.188 Per cent of youth in Grades 9 to 12 who have experienced bullying or personal threats at least once in the previous year, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved August 19, 2017.

In 2013/14, 31% of Grade 7 students experienced verbal bullying. The proportion of students experiencing verbal bullying declined with age; by Grade 12, 23% of students reported they had experienced verbal bullying. In 2013/14, 16% of Grade 7 students had experienced physical bullying compared to 9% in Grade 12. Between 12% and 14% of Grade 7 to 12 students experienced cyberbullying (Figure 6.189).

**Figure 6.189 Prevalence of bullying among youth in Grade 7 to 12, by Grade and type of bullying, Manitoba, 2013/14**



Source: Manitoba Education and Advanced Learning. Manitoba Provincial Report. Tell Them from Me: Bullying and School Safety. 2013/14.

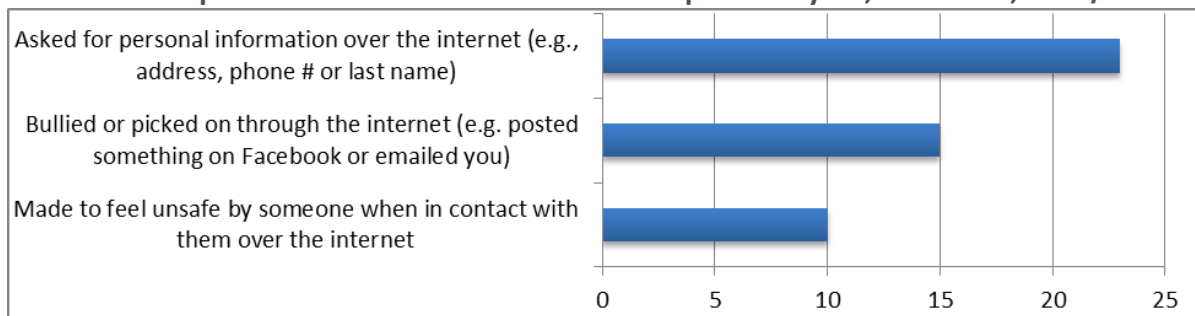
Girls were more likely to experience social bullying (27%) than were boys (19%). Girls were also more likely to experience cyber bullying (15%) than were boys (11%). Boys were more likely to experience physical bullying (14%) than were girls (10%).<sup>189</sup>

### Cyberbullying

We live in a connected world where it is easy to share information with thousands of people within seconds. This can have a positive outcome by bringing people together and creating fun online social communities, but it can also be used to hurt and abuse others. Online abuse is called cyberbullying.

Unlike other forms of bullying, cyberbullying can occur 24 hours a day and there is no escaping it. Abusers can hide behind their computer screen, remaining anonymous and sending hurtful information day and night. Because cyberbullies do not see the reaction of their words or taunts, they tend to lack empathy for their victims, making it easier to become more aggressive and vicious. This dehumanizing form of bullying is also easy to spread, as others who like or share the photos or words also feel a disconnection to the person at the end of the abuse.<sup>275</sup> Children who are cyberbullied feel an intense sense of isolation, fear, loneliness and despair. Sadly, this desperation can sometimes lead to acts of self-harm or even suicide abuse.<sup>275</sup> In 2012/2013, almost one-quarter (23%) of Manitoba youth in Grades 9 to 12 reported being asked for personal information over the internet, and 15% have been bullied or picked on through the internet (Figure 6.190).

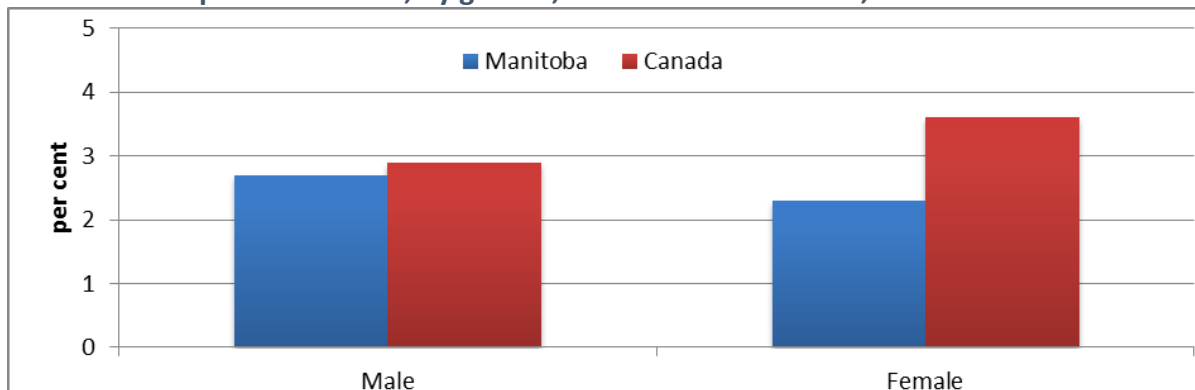
**Figure 6.190 Per cent of youth in Grades 9 to 12 who have experienced cyber bullying or personal threats at least once in the previous year, Manitoba, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

In 2014, according to the General Social Survey, 3% of Manitoba youth aged 15 to 24 years reported that they had been cyberbullied in the last year. This was the same for Canada overall. 2% of Manitoba young women reported being cyberbullied, compared to the rate of 4% for Canada overall (Figure 6.191).

**Figure 6.191 Per cent of youth ages 15 to 24 who report they have been cyberbullied in the past 12 months, by gender, Manitoba and Canada, 2014**



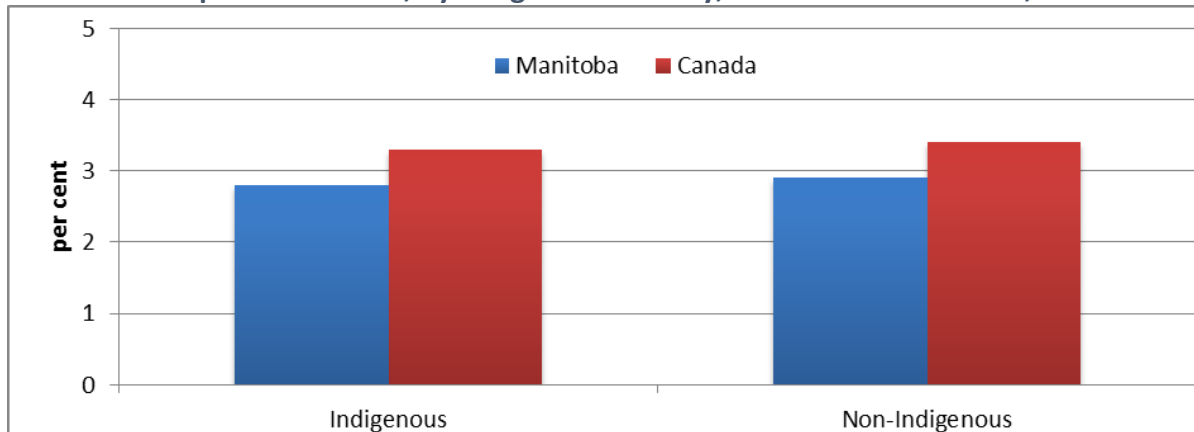
Source: Statistics Canada. 2016. General Social Survey, Cycle 28, 2014: Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

Note: Cyberbullying is defined as any of the following experiences: threatening, aggressive emails or texts, aggressive comments through emails or texts, pictures that embarrassed or threatened you, use of respondents identity to post information, other types of cyber stalking/bullying.



According to the 2014 General Social Survey, approximately 3% of both Indigenous and non-Indigenous youth ages 15 to 24, in Manitoba and Canada, reported being cyberbullied in the past year (Figure 6.192).

**Figure 6.192 Per cent of youth ages 15 to 24 who report they have been cyberbullied in the past 12 months, by Indigenous identity, Manitoba and Canada, 2014**



Source: Statistics Canada. 2016. General Social Survey, Cycle 28, 2014: Victimization, Main File [public use microdata file]. Ottawa, Ontario: Statistics Canada: Social and Aboriginal Statistics Division. Ottawa, Ontario: Data Liberation Initiative.

Note: Cyberbullying is defined as any of the following experiences: threatening, aggressive emails or texts, aggressive comments through emails or texts, pictures that embarrassed or threatened you, use of respondents identity to post information, other types of cyber stalking/bullying.

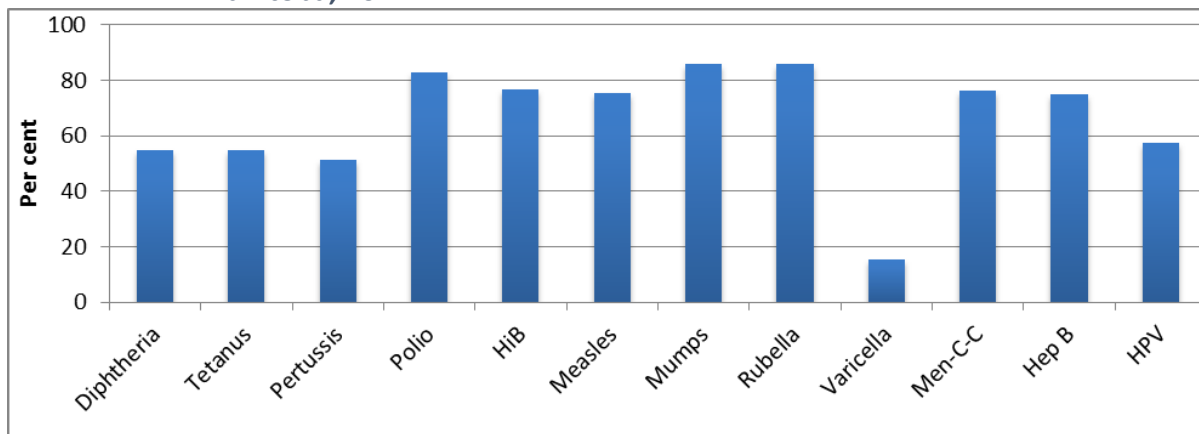
### 6.3.2 Immunization

Immunization is a cost-effective and successful public health intervention that protects the health of children and youth. It effectively prevents disease, improves the health of Canadians, and reduces pressures on our health care system. Although immunization recommendations are made at the national level, immunization is not mandatory in Canada. Immunization programs are delivered by the provinces and the territories.<sup>276</sup>

In Manitoba, in 2014, the immunization status of children at age 17 represents those who were born in 1997. Figure 6.193 provides the percentage of Manitoba 17-year-olds by complete for age by immunogen.<sup>88</sup>

When comparing Manitoba Regional Health Authorities, in 2014, Prairie Mountain Health had the highest percentage of children complete for age by immunogen at age 17. The Northern Health Region also had high immunization percentages for most immunogens. The Winnipeg Regional Health Authority had the lowest percentage of children per age by immunogen in almost every category.<sup>88</sup>

**Figure 6.193 Per cent of 17-year-olds who have had the recommended immunizations, Manitoba, 2014**



Source: Manitoba Immunization Monitoring System Annual Report 2014.

<http://www.gov.mb.ca/health/publichealth/surveillance/mims/index.html> (Accessed July 24, 2017)

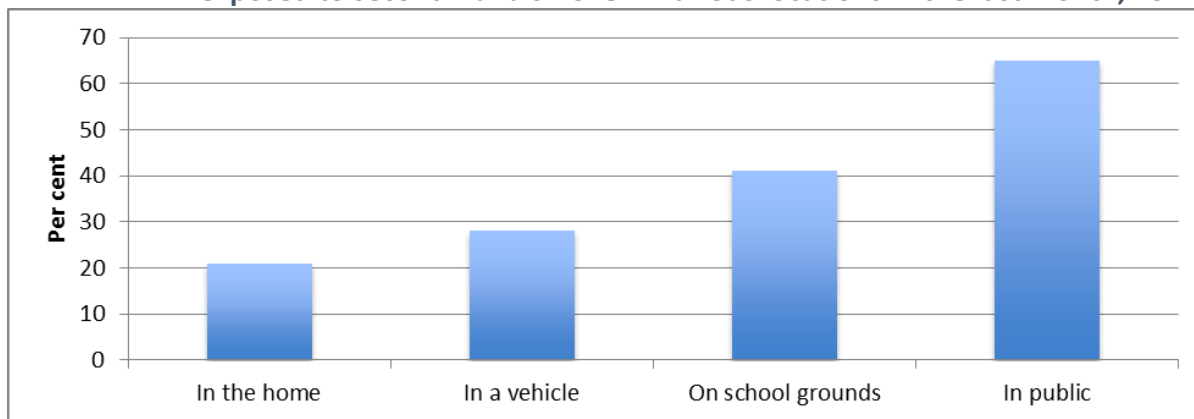
Notes: HiB: Haemophilus influenzae type b; Men C-C: Meningococcal conjugate C vaccine; HPV: Human papillomavirus; Hep B: Hepatitis B. To be considered complete for age overall at 17 years, children needed to have six doses of the immunogens diphtheria, tetanus, and pertussis; four doses of polio; three doses of hepatitis B, and HPV (females only); two doses of measles; and one dose each of mumps, rubella, varicella, and Men-C-C.

### 6.3.3 Second-Hand Smoke

Second-hand smoke is a combination of the smoke exhaled by smokers and the smoke released directly into the air from burning cigarettes, pipes and cigars, etc.<sup>277</sup> Children and youth are particularly susceptible to negative effects of second-hand smoke as they have little control over their exposure from smokers in cars and in the home.<sup>278</sup>

For youth, exposure to second-hand smoke has been associated with asthma, altered lung function and growth, infections, cardiovascular effects, behaviour problems, sleep difficulties, increased cancer risk, and a higher likelihood of starting to smoke.<sup>191,279</sup> Forty-nine per cent of Manitoba students in Grades 7 to 12 reported that they were exposed to second-hand smoke about once a month or more frequently.<sup>157</sup> In 2012/2013, 65% of Manitoba students in Grades 9 to 12 reported being exposed to second-hand smoke in public places. Exposure to second-hand smoke on school grounds was reported by 41% of Manitoban students, in a vehicle by 28%, in the home by 21%, and at work by 8% (Figure 6.194).

**Figure 6.194 Per cent of Manitoba students in Grades 9 to 12 who report that they were exposed to second-hand smoke in various locations in the last month, 2012/13**



Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved August 19, 2017.

### 6.3.4 Security

Income security, including adequate housing and food security, is of utmost importance for adolescent health and well-being. Living in poverty is considered to be the greatest health risk for adolescents, and is closely related to their likelihood of physical illness, mental health, obesity, high-risk behaviours, injury, and self-rated health.<sup>227,280</sup> Please refer to *Chapter 2: Who Are Manitoba's Children and Youth?* for further information on poverty and low-income in Manitoba.

Youth receiving income assistance are living in poverty, and are at a higher risk of behavioural and emotional difficulties, poor academic performance, and poorer health outcomes.<sup>131</sup>

#### **Employment and Income Assistance Program**

The Employment and Income Assistance (EIA) Program provides financial help to Manitobans who have no other way to support themselves or their families. This includes benefits from the Rent Assist Program that helps with housing costs. For people who are able to work, EIA will help them go back to work by providing supports to employment.

The major objectives of the EIA program are:

- to assist Manitobans in regaining their financial independence by helping them to make the transition from income assistance to work; and
- to provide income assistance to Manitobans in need.

Financial assistance is provided to persons in need who are eligible for assistance under *The Manitoba Assistance Act* (the Act), including single parents, aged persons, single persons, couples without children, two-parent families, persons with disabilities, persons requiring the protection of a crisis intervention facility, and children whose parents are unable to support them. Eligibility may be granted under special case consideration at the discretion of the Minister.

Eligibility for assistance is also determined by a needs test, in which the amount of a household's financial resources is compared to the total costs of basic necessities as defined in the Act and Regulations. Certain assets and income are not included in the calculation of financial resources.

EIA provides employability assessments, support in the development and implementation of a plan to achieve well-being or personal stability and readiness to participate in an employment or training plan, work incentives and other supports to assist Manitobans in entering, re-entering or remaining in the labour force.

For further information, please go to: <http://www.gov.mb.ca/fs/eia/>

In 2015/16, on average, 1,844 youth 18 and 19 years of age were on EIA, or 2.8% of all people on EIA, while youth on EIA account for 5.1% of the Manitoba population (Table 6.4).

**Table 6.4 Average monthly youth on Employment and Income Assistance, Manitoba, 2011/12 to 2015/16**

<b>Year</b>	<b>18-year-olds on EIA</b>	<b>19-year-olds on EIA</b>	<b>EIA youth as a percentage of all people on EIA</b>	<b>EIA youth as a percentage of all Youth in Manitoba*</b>
<b>2011/12</b>	<b>786</b>	<b>921</b>	<b>2.7%</b>	<b>*</b>
<b>2012/13</b>	<b>802</b>	<b>941</b>	<b>2.8%</b>	<b>4.8%</b>
<b>2013/14</b>	<b>793</b>	<b>957</b>	<b>2.8%</b>	<b>4.7%</b>
<b>2014/15</b>	<b>805</b>	<b>1,004</b>	<b>2.9%</b>	<b>4.9%</b>
<b>2015/16</b>	<b>827</b>	<b>1,017</b>	<b>2.8%</b>	<b>5.1%</b>

Source: Population data is from the Department of Manitoba Health's Annual Population Reports. EIA data is derived from monthly extracts of the SAMIN database.

\* As the 2011 Population Report is unavailable online, calculations cannot be made.

Note: The population counts for 18- and 19-year-olds include individuals living on reserve, while EIA covers only the off-reserve population.

Youth can be broken down into regions according to district office groupings based on where the participants received EIA services, as opposed to where they lived. In 2015/16, the majority (61%) of 18- and 19-year-olds on EIA were in Winnipeg and 23% were in Rural South (Table 6.5).

**Table 6.5 Average monthly number of 18- and 19-year-olds on EIA by year and region, Manitoba, 2011/12 to 2015/16**

<b>Year</b>	<b>Rural South</b>	<b>Winnipeg</b>	<b>Brandon</b>	<b>Thompson</b>	<b>North (excl Thompson)</b>	<b>Total</b>
<b>2015/16</b>	<b>415</b>	<b>1,119</b>	<b>153</b>	<b>90</b>	<b>67</b>	<b>1,843</b>
<b>2014/15</b>	<b>415</b>	<b>1,093</b>	<b>156</b>	<b>88</b>	<b>57</b>	<b>1,809</b>
<b>2013/14</b>	<b>402</b>	<b>1,049</b>	<b>154</b>	<b>92</b>	<b>54</b>	<b>1,751</b>
<b>2012/13</b>	<b>400</b>	<b>1,049</b>	<b>158</b>	<b>76</b>	<b>60</b>	<b>1,743</b>
<b>2011/12</b>	<b>369</b>	<b>1,050</b>	<b>149</b>	<b>81</b>	<b>56</b>	<b>1,707</b>

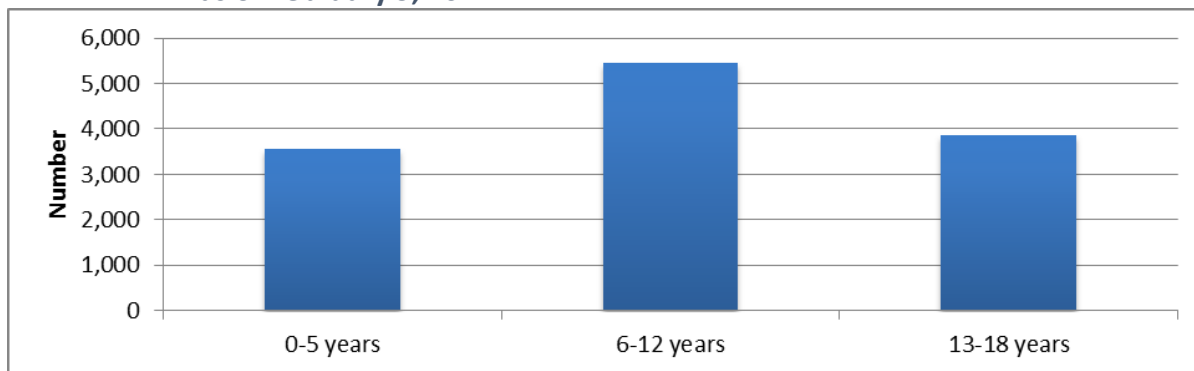
Source: Monthly extracts of the SAMIN database.

Notes: Region is based on district office. "Rural" is effectively what does not fit into the other groupings. As the data is not mapped according to a participant's residence, there is no good comparator for a percentage of the overall youth population on EIA in the region.

### *Housing*

Manitoba Housing provides a wide range of subsidized housing throughout the province including subsidized rental housing and cooperative housing. As of February 9, 2017, there were 3,866 youth aged 13 to 18 years living in Manitoba Housing direct managed units (Figure 6.195).

**Figure 6.195 Number of children living in Manitoba Housing by age group, Manitoba, as of February 9, 2017**

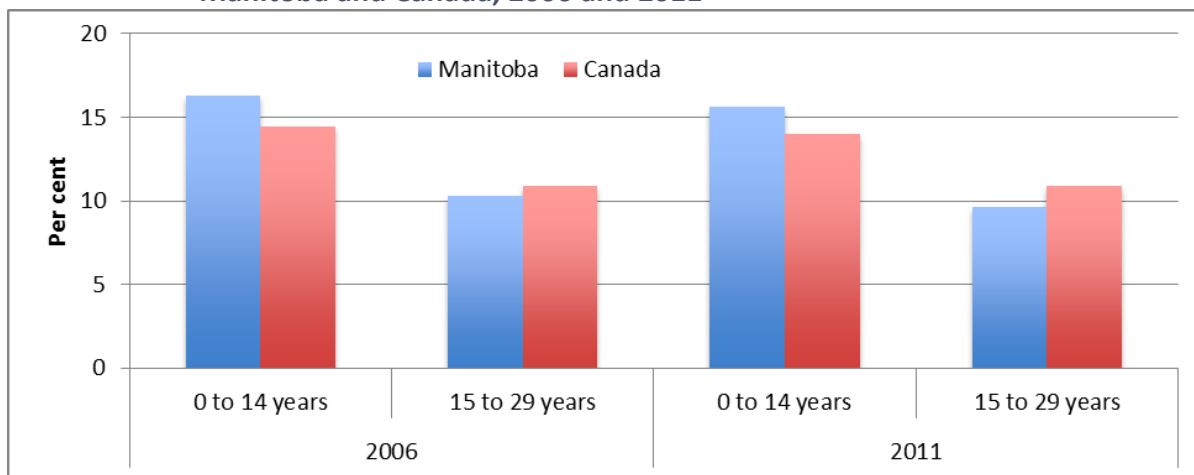


Source: Housing Division, Department of Families

Families are said to live in “core housing need” if their housing falls below standards of adequacy, affordability or suitability, and they would have to spend 30% or more of their total before-tax income to access acceptable local housing.<sup>28</sup>

The percentage of Manitoba children and youth aged 0 to 14 years living in core housing need remained at 16% in 2006 and 2011. It was 10% in both years for 15- to 29-year-olds. In 2011, the Canadian overall core housing need for 0- to 14-year-olds was 14% and it was 11% for 15- to 29-year-olds (Figure 6.196).

**Figure 6.196 Per cent of children and youth living in core housing need, by age group, Manitoba and Canada, 2006 and 2011**



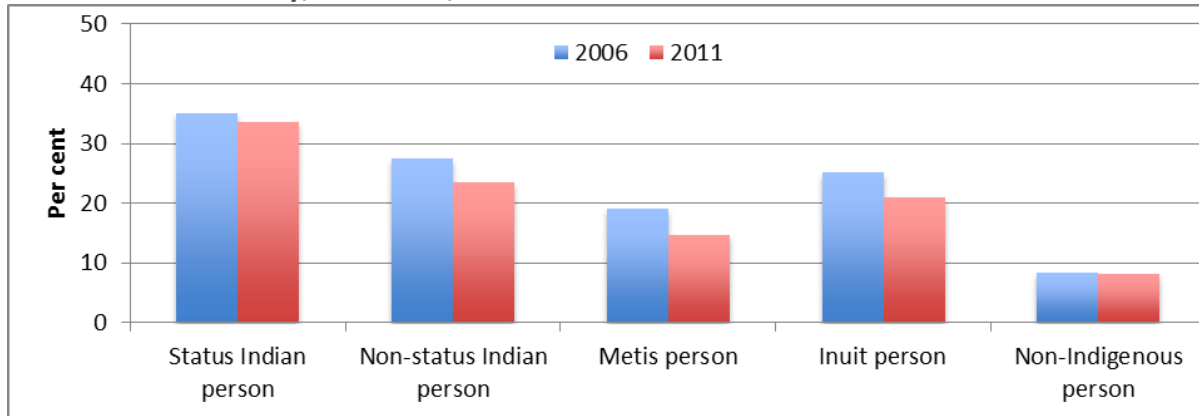
Source: Canadian Housing Observer. Core Housing Need Status for the Population, by Selected Characteristics and Gender, Manitoba, 2011 & 2006. [https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/data\\_025.cfm](https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/data_025.cfm)

Notes: Core housing needs are defined as: “A household is said to be in core housing need if its housing falls below at least one of the adequacy, affordability or suitability, standards and it would have to spend 30% or more of its total before-tax income to pay the median rent of alternative local housing that is acceptable (meets all three housing standards). Adequate housing is reported by residents as not requiring any major repairs. Affordable dwellings costs less than 30% of total before-tax household income. Suitable housing has enough bedrooms for the size and make-up of resident households, according to National Occupancy Standard (NOS) requirements. A household is not in core housing need if its housing meets all of the adequacy, suitability and affordability standards, OR if its housing does not meet one or more of these standards, but it has sufficient income to obtain alternative local housing that is acceptable (meets all three standards). Regardless of their circumstances, non-family households led by maintainers 15 to 29 years of age attending school full-time are considered to be in a transitional stage of life and therefore not in core housing need.”

In 2006 and 2011, Indigenous Manitobans were living in core housing need at a higher rate than non-Indigenous Manitobans. In Manitoba, just over 8% of Non-Indigenous people reported

they were living in core housing need in both 2006 and 2011. Manitoba Status Indians had the highest rate at 35% in 2006, reducing only slightly in 2011 (34%). Non-Status Indian persons were the next Indigenous group in the greatest core housing need with 28% requiring this support in 2006 and 24% in 2011. Inuit core housing need percentages were also high at 25% in 2006 and 21% in 2011. Although the lowest in need of the Indigenous group, the Métis percentage of 19% in 2006 and 15% in 2011 was still double that of the Non-Indigenous people in Manitoba for those years (Figure 6.197).

**Figure 6.197 Per cent of the Manitoba population living in core housing need, by Indigenous identity, Manitoba, 2006 and 2011**



Source: Canadian Housing Observer. Core Housing Need Status for the Population, by Selected Characteristics and Gender, Manitoba, 2011 & 2006. [https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/data\\_025.cfm](https://www.cmhc-schl.gc.ca/en/hoficlincl/homain/stda/data/data_025.cfm)

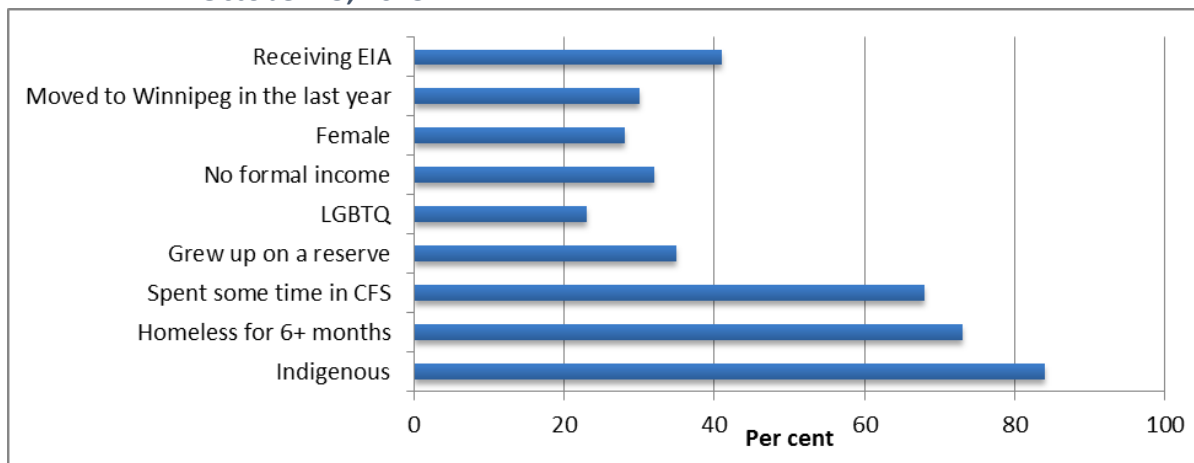
Notes: Core housing needs are defined in Figure 6.196.

### *Homelessness*

According to the Winnipeg Street Census, at least 1,400 people were homeless, 27% were youth between the ages of 16 to 29, on the day the census was taken, October 25, 2015. The number one reason why youth become homeless was due to family breakdown, conflict and/or violence. Individuals tended to first become homeless around 18 years of age. The majority (70%) of people who experienced long-term (10+ years) homelessness first became homeless as a youth.

Of the 1,400 people (youth and adults) that were homeless in Winnipeg on October 25, 2015, 84% were Indigenous, 73% had been homeless for over 6 months, 68% had spent time in Child Family Services (CFS), 35% had grown up on reserve, 23% identified as LGBT2SQ+, 32% had no formal income, 28% were female, 30% had moved to Winnipeg in the last year and 41% were receiving EIA (Figure 6.198).

**Figure 6.198 Characteristics of homeless youth, ages 16 to 29, in Winnipeg, Manitoba, October 25, 2015**

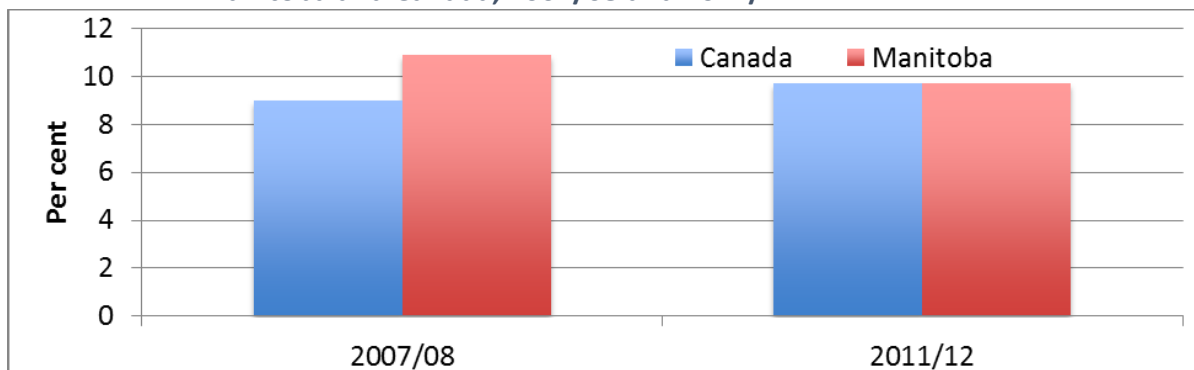


Source: Maes Nino C, Godoy M, McCullough S, Retzlaff B, Wiebe A, Wurcherer L. The Winnipeg Street Census 2015: Final Report. Winnipeg: Social Planning Council of Winnipeg; 2016. Retrieved from [http://streetcensuswpg.ca/wp-content/uploads/2016/01/WSC\\_FinalReport\\_Jan15\\_2016\\_WebVersion.pdf](http://streetcensuswpg.ca/wp-content/uploads/2016/01/WSC_FinalReport_Jan15_2016_WebVersion.pdf)

### Food security

In 2011/12, 10% of Manitoba children 6 to 17 years of age lived in households that had moderate or severe food insecurity compared to 11% in 2007/08. The rate for Manitoba was higher than Canada in both years (Figure 6.199).

**Figure 6.199 Per cent of households with children ages 6 to 17 experiencing food insecurity, Manitoba and Canada, 2007/08 and 2011/12**

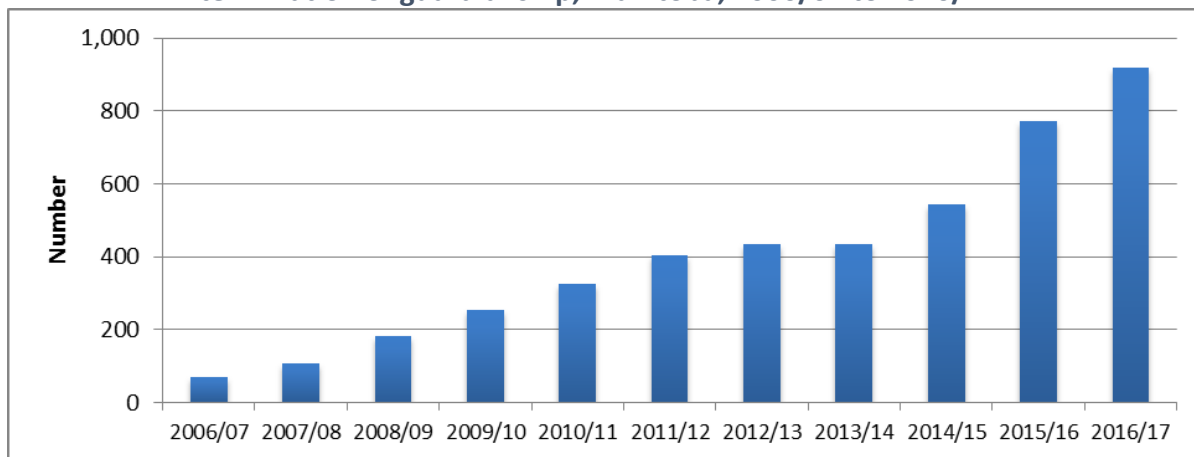


Source: Statistics Canada. Table 105-0546 - Household food insecurity measures, by presence of children in the household, Canada, provinces and territories, occasional (number unless otherwise noted) <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1050546> (Accessed September 11, 2017)

### Services to young adults

Youth who are permanent wards of a CFS agency can receive financial support beyond their 18th birthday and up to the age of 21 under certain circumstances. The key goal is to facilitate a successful transition from being a youth in CFS care to independence. The number of Manitoba youth receiving support from CFS beyond termination of guardianship has been increasing since 2006, when 71 Manitoba youth received this support. CFS support more than doubled to 183 by 2008 and nearly 13 times greater to 917 youth by 2017 (Figure 6.200).

**Figure 6.200** Number of youth receiving Child and Family Services support beyond termination of guardianship, Manitoba, 2006/07 to 2016/17



Sources: 2006-2014: Child and Family Services (CFS) Overview and Statistics; <https://www.gov.mb.ca/fs/childfam/investments.html>. 2015/16 & 2016/17: Manitoba Family Services Annual Reports 2015/16 and 2016/17; [www.gov.mb.ca/fs/about/annual\\_reports.html](http://www.gov.mb.ca/fs/about/annual_reports.html).

## 6.4 Successful at Learning

Academic learning becomes an increasing focus for youth who are contemplating post-secondary education. Studies have shown that early academic success tends to predict success later in life. However, life skills and cultural learning are also important aspects of preparing teens for independence and their roles as adults.

### 6.4.1 Successful Grade 9 Credit Attainment

Grade 9 is the first year in Manitoba schools when students must pass core courses toward earning their high school diploma. For many, this transition year can mean declines in academic achievement and increased absences among other social factors that impact their success. Research shows that success in Grade 9 credit attainment is a critical determinant of a student's likelihood of successfully completing high school.

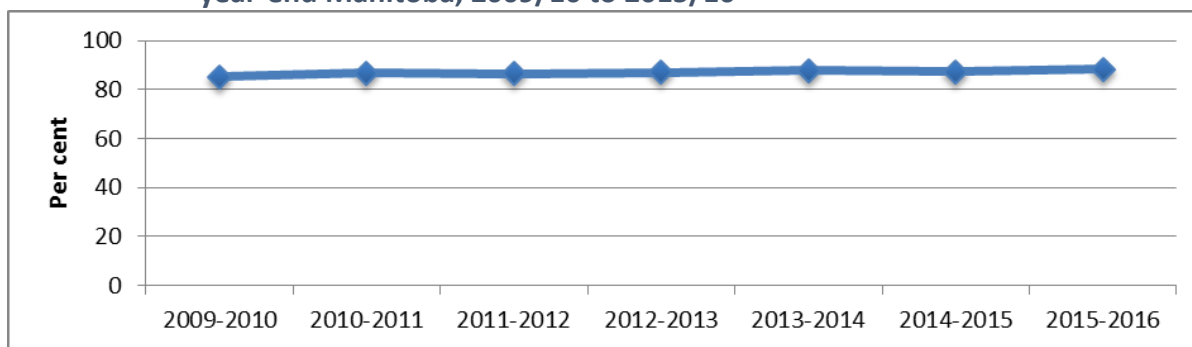
Manitoba's Grade 9 credit attainment information includes students from public and funded independent schools as well as students from First Nations schools administered by Frontier School Division under educational agreements.<sup>207</sup>

### 6.4.2 Mathematics

In 2015/16, 88% of first-time Grade 9 students attained a mathematics credit by the end of the year. This rate has been relatively stable since 2009/10. The proportions were similar for male and female students (Figure 6.201).



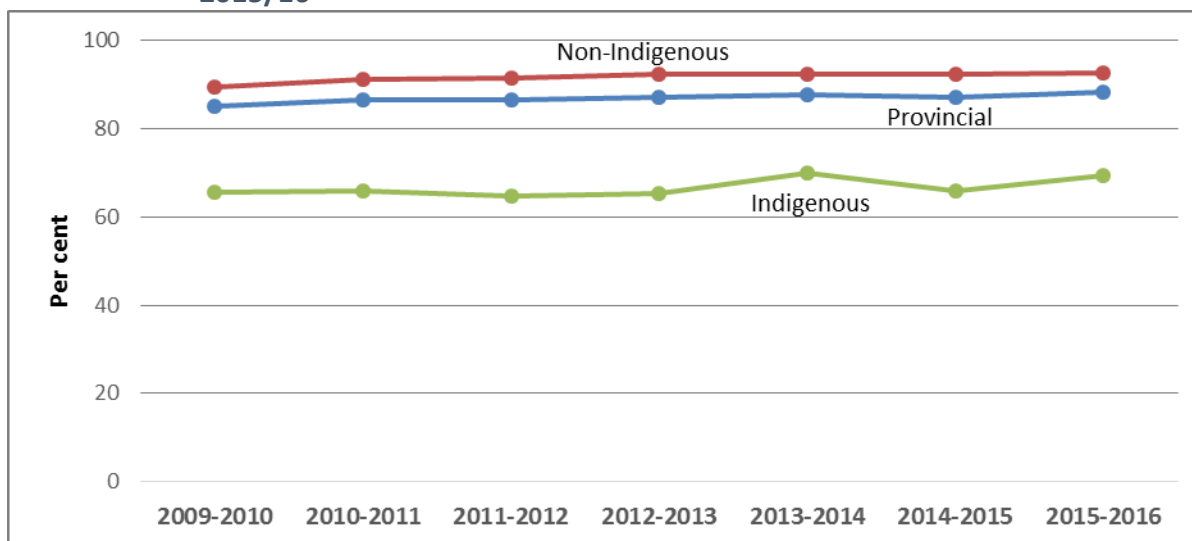
**Figure 6.201** Per cent of first-time Grade 9 students who attained a mathematics credit by year-end Manitoba, 2009/10 to 2015/16



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

In 2015/16, 69% of Indigenous Grade 9 students attained a mathematics credit by year-end, compared to 66% in 2009/10. Attainment was 93% for non-Indigenous students in 2015/16 compared to 90% in 2009/10 (Figure 6.202).

**Figure 6.202** Per cent of first-time Grade 9 students who attained a mathematics credit by year-end, Indigenous and non-Indigenous students, Manitoba, 2009/10 to 2015/16

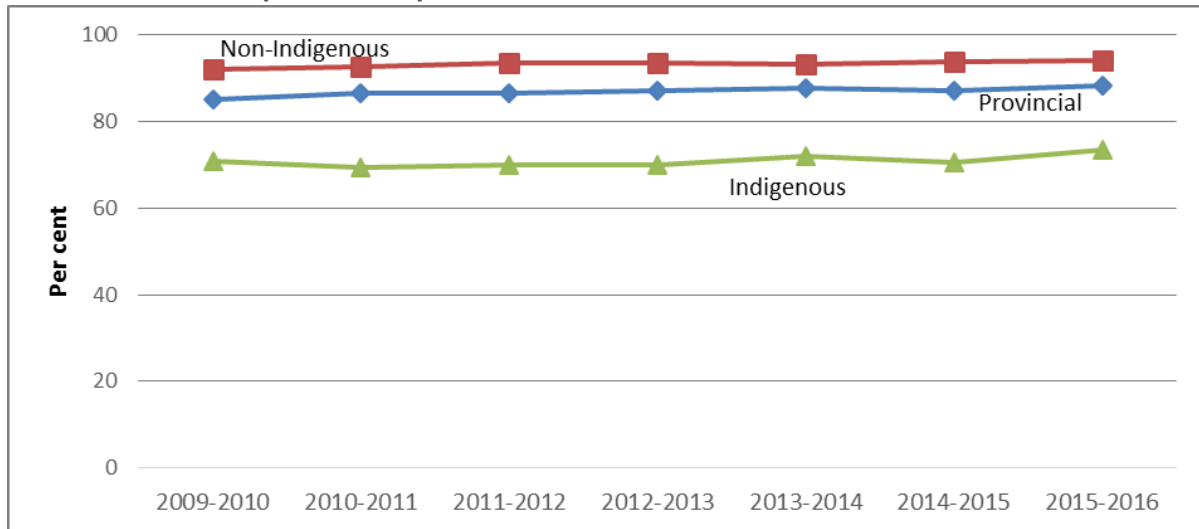


Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

### 6.4.3 Grade 9 Language Arts

In 2015/16, 74% of Indigenous first-time Grade 9 students attained an English Language Arts credit. That rate was 71% in 2009/10 (Figure 6.203). The rate was 94% for non-Indigenous students in 2015/16 and was 92% in 2009/10. The provincial rate overall was 90% in 2015/16 compared to 88% in 2009/10 (Figure 6.203).

**Figure 6.203** Per cent of first-time Grade 9 students who attained an English Language Arts credit by year-end, Indigenous and non-Indigenous students, Manitoba, 2009/10 to 2015/16



Source: Manitoba Government, Department of Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

#### 6.4.4 Grade 12 Provincial Tests

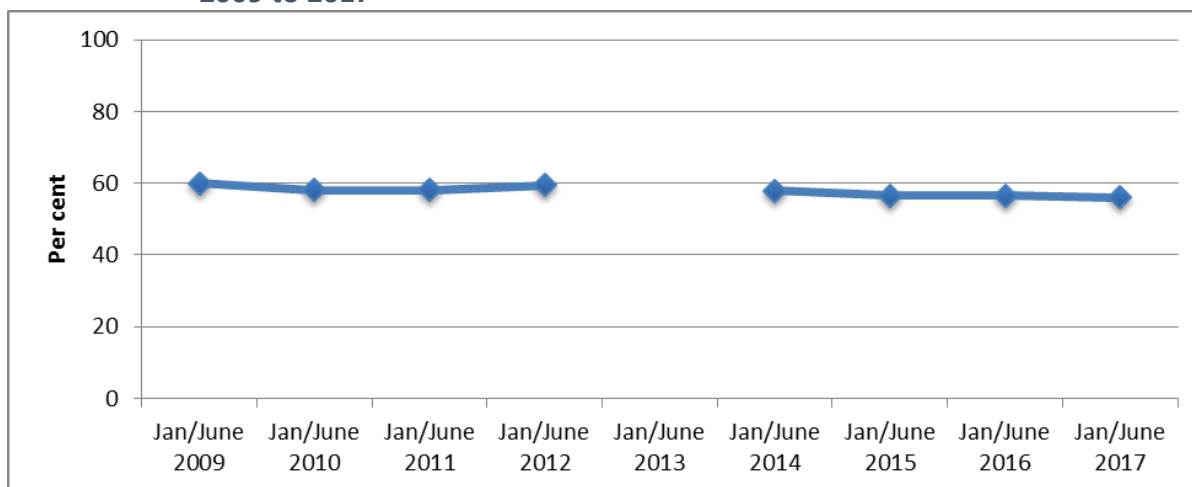
Students in Grade 12 in Manitoba are required to write standard provincial examinations in Language Arts and Math. These tests certify academic achievement and are also used by teachers to evaluate academic instruction and to improve student learning.

#### 6.4.5 Applied Mathematics

Applied mathematics involves problem solving, communication, reasoning, and mental math. Students engage in a variety of activities that promote the practical application of symbolic math ideas to the world around them, including linear and non-linear functions, logic, probability, counting techniques, finance, and design and measurement.<sup>281</sup>

In the period January/June 2009, the average mark in Grade 12 applied mathematics was 60% and in January/June 2017, it was 56% (Figure 6.204). The rates were similar for males and females in all years from 2009 to 2017. The scores are not available for 2013.

**Figure 6.204 Average marks in provincial tests in Grade 12 applied mathematics, Manitoba, 2009 to 2017**

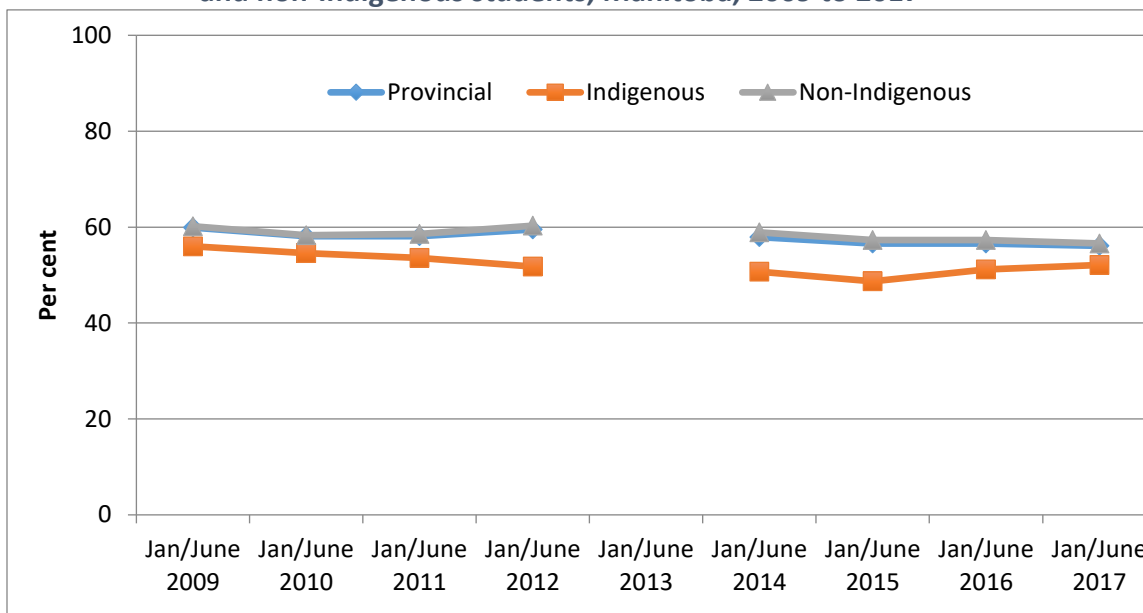


Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

Note: No results are available for January and June 2013. New mathematics tests based on new curricula were administered in the context of a provincial pilot process.

In the period January/June 2017, the average mark in Grade 12 applied mathematics for Indigenous students was 52.1% compared to 56.6% among non-Indigenous students. The average marks among Indigenous students declined between 2009 and 2014 but increased from 2015 on (Figure 6.205). Overall provincial results are nearly the same as non-Indigenous results for all years.

**Figure 6.205 Average marks in provincial tests in Grade 12 applied mathematics, Indigenous and non-Indigenous students, Manitoba, 2009 to 2017**



Source: Manitoba Government, Department of Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

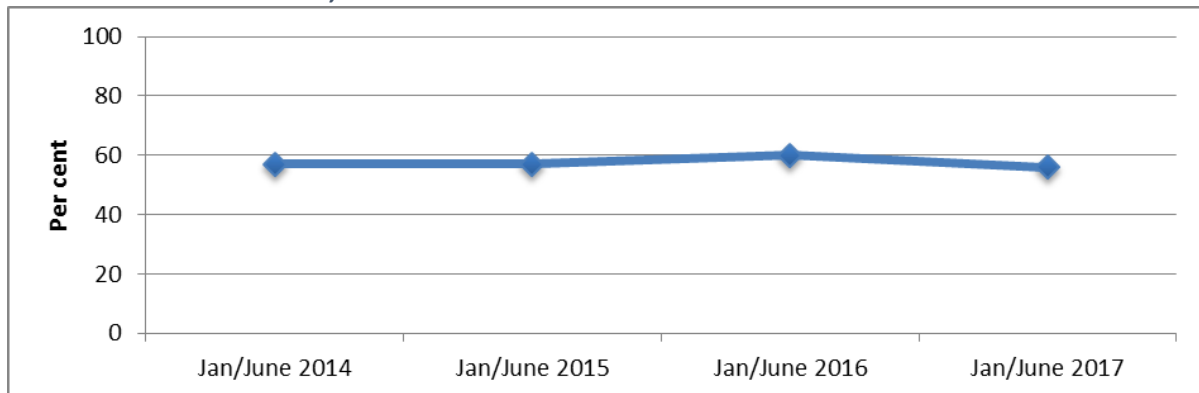
Note: Every year, parents of new or continuing students are given the opportunity to indicate if they are declaring their child's Indigenous identity for the first time, or altering their child's previously declared identity, or confirming that a previous declaration has been made. No results are available for January and June 2013. New mathematics tests based on new curricula were administered in the context of a provincial pilot process.

### 6.4.5.1 Essential mathematics

Essential mathematics is designed to provide students with mathematical understandings and critical-thinking skills. Topics taught as part of essential mathematics include: algebra, geometry, measurement, statistics and probability.

In the period January/June 2014, the average mark in Grade 12 essential mathematics was 57% and in January/June 2017, it was 56% (Figure 6.206). There were no gender differences in all four years.

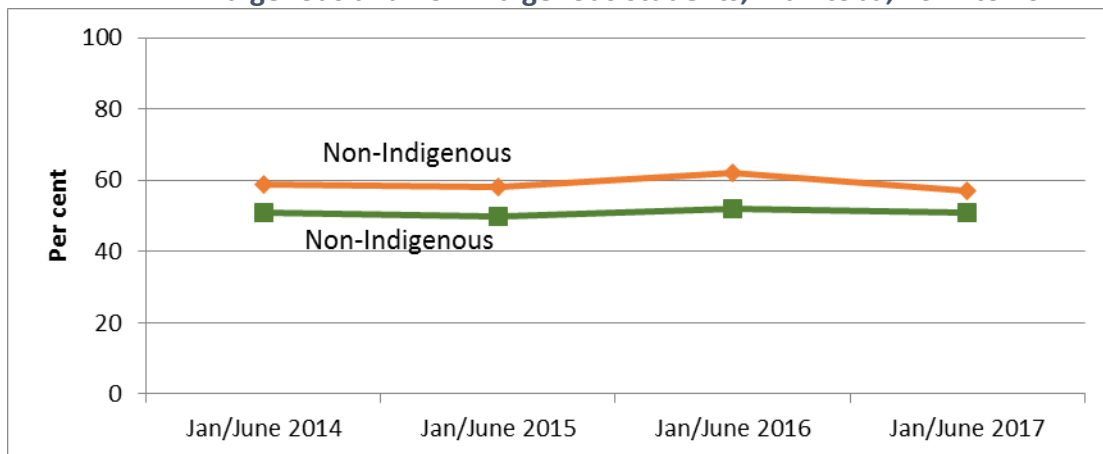
**Figure 6.206 Average marks in provincial tests in Grade 12 essential mathematics, Manitoba, 2014 to 2017**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

In the period January/June 2017, the average grade in Grade 12 essential mathematics for Indigenous students was 51% compared to 56% for non-Indigenous students. The average marks among Indigenous and non-Indigenous students remained stable between 2014 and 2017 (Figure 6.207).

**Figure 6.207 Average marks in provincial tests in Grade 12 essential mathematics, Indigenous and non-Indigenous students, Manitoba, 2014 to 2017**



Source: Manitoba Government, Department of Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

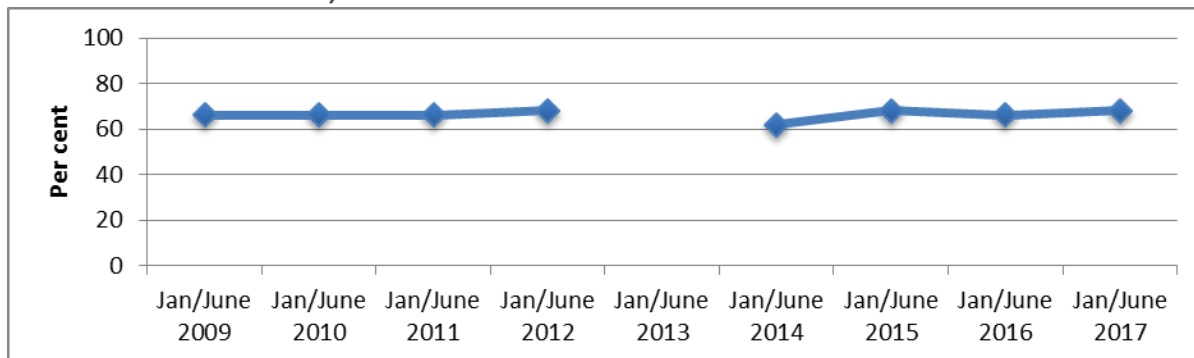
### 6.4.5.2 Pre-calculus mathematics

Pre-calculus mathematics is designed to provide students with the mathematical understandings and critical-thinking skills needed for entry into post-secondary programs that

require the study of theoretical calculus. Topics taught as part of pre-calculus mathematics include: algebra, measurement, permutations, combinations and binomial theorem, relations and functions, and trigonometry.<sup>282</sup>

In the period January/June 2009, the average mark in Grade 12 pre-calculus mathematics was 66%. In January/June 2017, it was 68% (Figure 6.208). There were little differences between males and females: In the period January/June 2017, the average mark was 68% for males and 69% for females.

**Figure 6.208 Average marks in provincial tests in Grade 12 pre-calculus mathematics, Manitoba, 2009 to 2017**

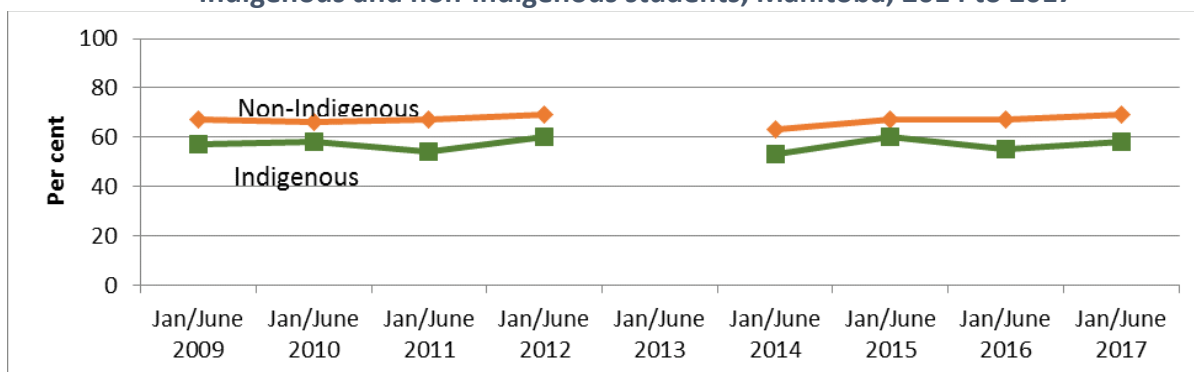


Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

Note: No results are available for January and June 2013. New mathematics tests based on new curricula were administered in the context of a provincial pilot process.

In the period January/June 2017, the average grade in Grade 12 pre-calculus mathematics for Indigenous Grade 12 students was 58% compared to 69% for non-Indigenous students. The average grades among Indigenous students remained stable between 2014 and 2017 (Figure 6.209).

**Figure 6.209 Average marks in provincial tests in Grade 12 pre-calculus mathematics, Indigenous and non-Indigenous students, Manitoba, 2014 to 2017**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

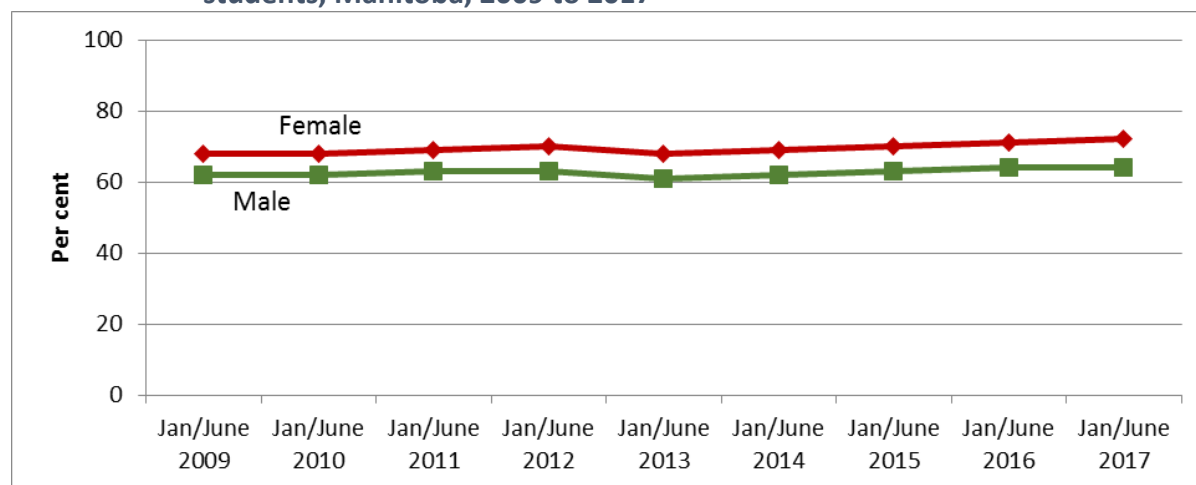
Note: No results are available for January and June 2013. New mathematics tests based on new curricula were administered in the context of a provincial pilot process.

#### 6.4.6 Language Arts

In 2017, the provincial average mark for the Grade 12 Language Arts Examination was 68%, up from 65% in 2009. Young women had higher average marks than young men from 2009 to 2016

(Figure 6.210). In 2017, the average mark for Indigenous students was 60%, relatively stable since 2009. The average mark for non-Indigenous students was 69% in 2017, up from 66% in 2009.

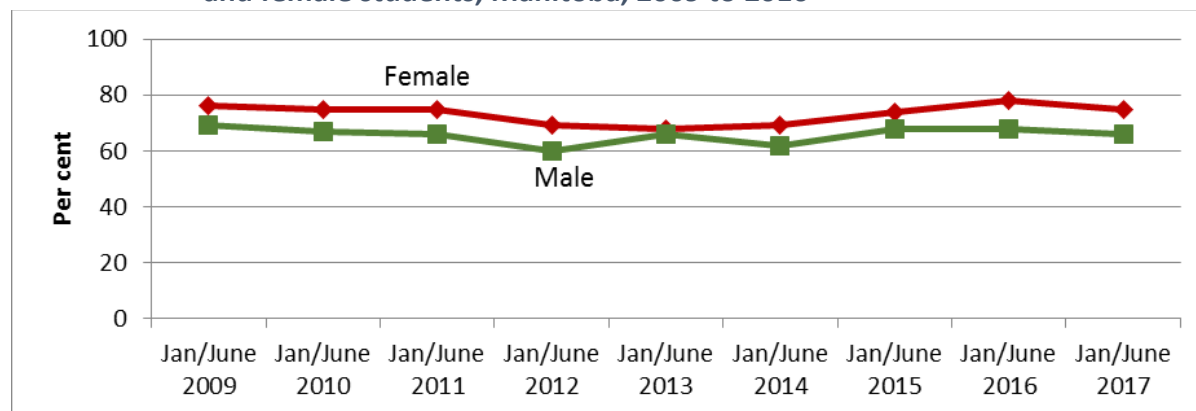
**Figure 6.210 Average marks in provincial tests in Grade 12 language arts, male and female students, Manitoba, 2009 to 2017**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

In 2017, the average mark for the Grade 12 French Examination in the Français Program was 71%. The rate fluctuated from a high of 73% in 2009 to a low of 65% in 2012. Young women had higher average scores than young men from 2009 to 2017 (Figure 6.211). In 2017, the average mark for Indigenous students was 64%. It was 74% in 2009. The average mark for non-Indigenous students was 73% in 2017.

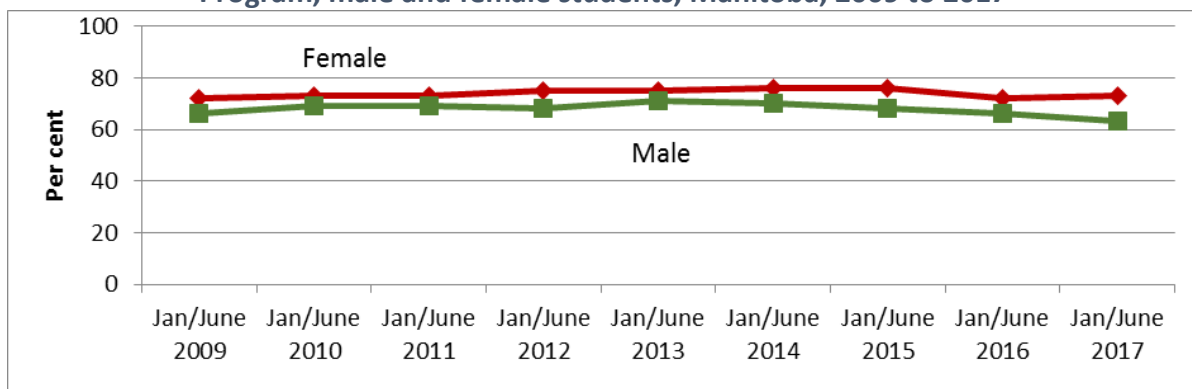
**Figure 6.211 Average marks in provincial tests in Grade 12 French, Français Program, male and female students, Manitoba, 2009 to 2016**



Source: Manitoba Government, Department of Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

In 2017, the average mark for the Grade 12 French Examination in the French Immersion Program was 69%. The rate was 69% in 2009, rose to 73% from 2013 to 2015, and then went back down to 69%. Young women had higher average marks than did young men consistently from 2009 to 2016, averaging 74% for all eight years, compared to 68% for males (Figure 6.212). In 2017, the average mark for Indigenous students was 67%. It was 63% in 2009. The average mark for non-Indigenous students was 69% in 2017.

**Figure 6.212 Average marks in provincial tests in Grade 12 French, French Immersion Program, male and female students, Manitoba, 2009 to 2017**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/](http://www.edu.gov.mb.ca/k12/grad_rates/)

## 6.4.7 Programme for International Student Assessment (PISA)

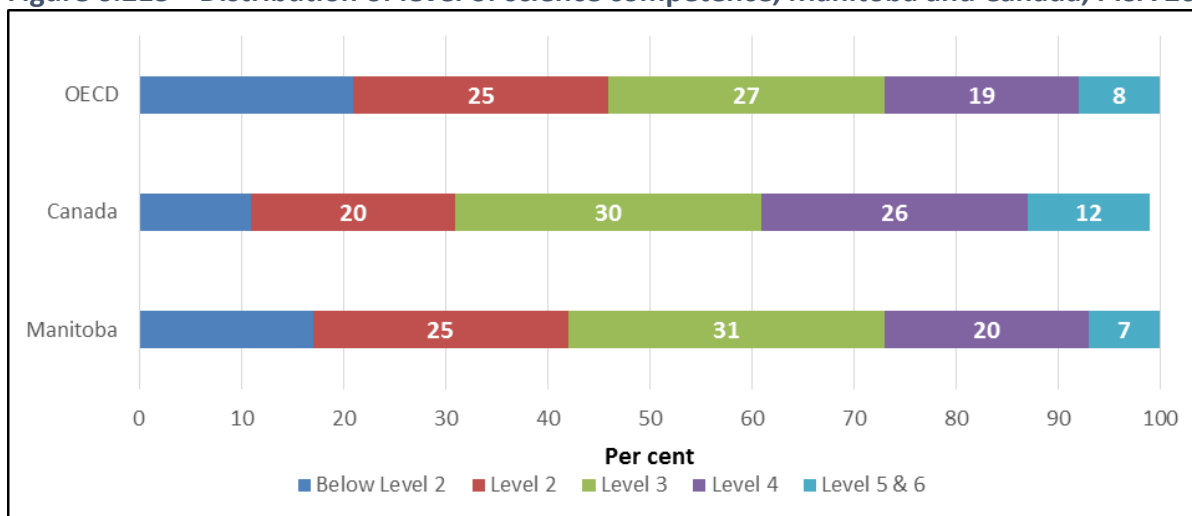
### 6.4.7.1 Science proficiency

Students in Manitoba and across Canada participate in a number of international learning assessments. One of these is the PISA, developed by the Organisation for Economic Co-operation and Development (OECD). PISA surveys mathematics, reading and science skills among 15-year-olds.

In 2015, PISA examined scientific literacy. PISA defines scientific literacy as the ability to engage with science-related issues, and with the ideas of science, as a reflective citizen. A scientifically literate person is willing to engage in reasoned discourse about science and technology, which requires the competencies to explain phenomena scientifically, evaluate and design scientific enquiry, and interpret data and evidence scientifically.

According to PISA 2015, 83% of Manitoba students performed at or above Level 2 in science, which is the baseline level of science proficiency. That rate was 89% in Canada overall and 79% for all students in the OECD countries (Figure 6.213).

**Figure 6.213 Distribution of level of science competence, Manitoba and Canada, PISA 2015**



Source: Measuring up: Canadian Results of OCED PISA Study (2015): The performance of Canada's Youth in Science, Reading and Mathematics <https://www.cmec.ca/Publications/Lists/Publications/Attachments/365/PISA2015-CdnReport-EN.pdf>

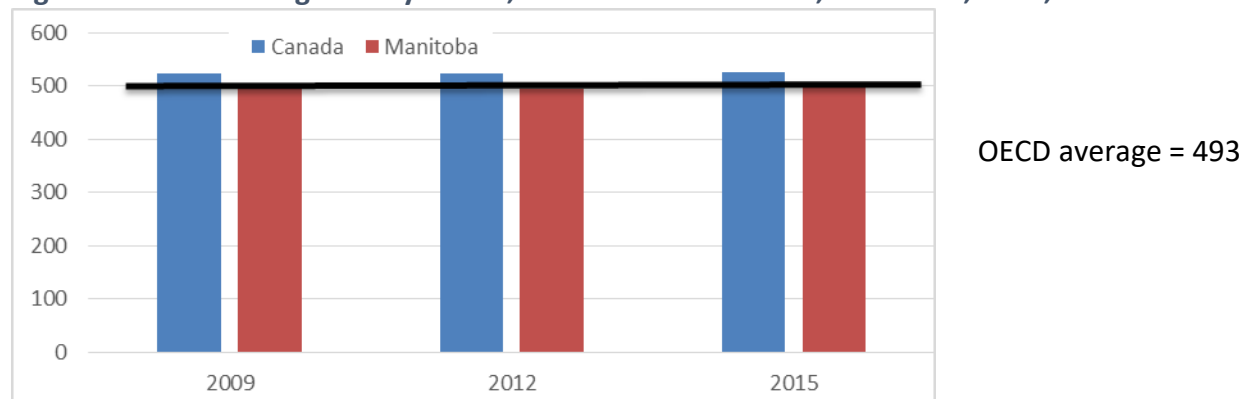
Manitoba's average score was 499 (standard error (SE) = 4.7); Canada's was 528 (SE = 2.1); and the OECD's was 493 (SE = 0.4). In Manitoba, students in the English and French Immersion language school systems performed better than students in the French school system. There was no statistically significant difference between the performance of girls and boys.

#### 6.4.7.2 Reading literacy

PISA also measures reading literacy. The test emphasizes functional knowledge and skills that allow active participation in society. PISA defines reading literacy as an individual's capacity to understand, use, reflect on, and engage with written texts, to achieve one's goals, develop one's knowledge and potential, and participate in society.

Manitoba's average score in reading literacy in 2015 was 498 (SE = 5.0); Canada's was 528.7 (SE = 2.3); and the OECD's was 493 (SE = 0.5). The scores in Canada and Manitoba have been stable since 2009. Girls performed significantly better than boys on the reading literacy test in Manitoba (Figure 6.214).

**Figure 6.214 Reading literacy scores, Manitoba and Canada, PISA 2009, 2012, 2015**



Source: Measuring up: Canadian Results of OECD PISA Study (2015): The performance of Canada's Youth in Science, Reading and Mathematics. <https://www.cmec.ca/Publications/Lists/Publications/Attachments/365/PISA2015-CdnReport-EN.pdf>

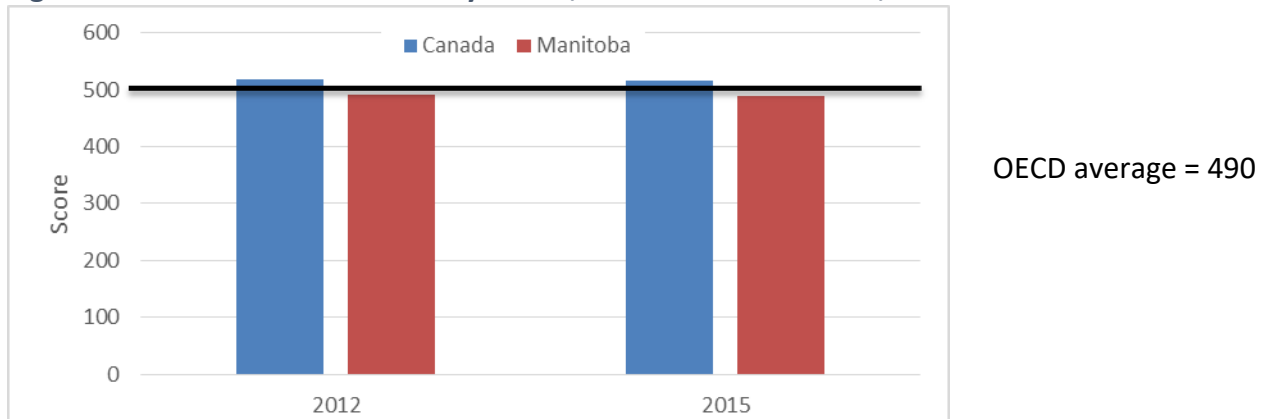
#### 6.4.7.3 Mathematics literacy

The PISA mathematics test emphasizes functional knowledge and skills that allow active participation in society. Mathematical literacy is defined as an individual's capacity to formulate, employ, and interpret mathematics in a variety of contexts. It includes reasoning mathematically and using mathematical concepts, procedures, facts, and tools to describe, explain, and predict phenomena. It assists individuals to recognize the role that mathematics plays in the world and to make the well-founded judgments and decisions needed by constructive, engaged, and receptive citizens.

In 2015, Manitoba's average mathematics literacy score was 489 (SE = 4.2); Canada's was 516 (SE = 2.3); and the OECD's was 490 (SE = 0.4). The Canadian and Manitoba scores have been relatively stable since 2012 (Figure 6.215). There was no difference between girls' and boys' performances on the mathematics test in Manitoba.



**Figure 6.215 Mathematics literacy scores, Manitoba and Canada, PISA 2012 and 2015**



Source: Measuring up: Canadian Results of OCED PISA Study (2015): The performance of Canada's Youth in Science, Reading and Mathematics. <https://www.cmec.ca/Publications/Lists/Publications/Attachments/365/PISA2015-CdnReport-EN.pdf>

### **6.4.8 High School Graduation and Post-secondary Enrolment**

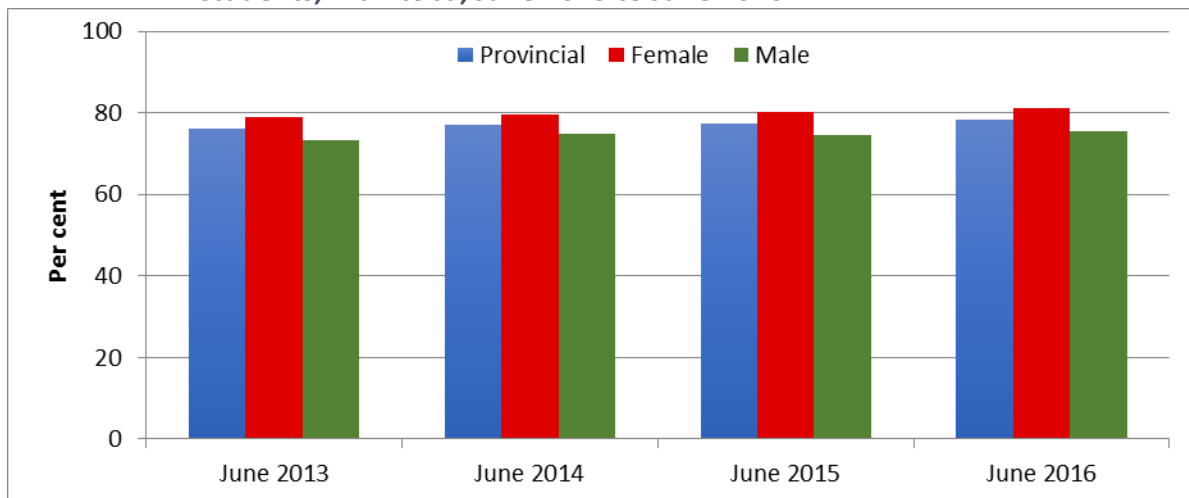
High school graduation is generally viewed as the minimum requirement for pursuing additional education and for entry into the world of work.

Manitoba's student-tracked method allows us to accurately understand how long it takes for individual students to graduate and to help us better identify certain achievement gaps, such as those between male and female students and between Indigenous and non-Indigenous students.

High school graduation in Manitoba typically occurs within four years of beginning Grade 9. This is referred to as "on-time" graduation. For some students, and for a variety of reasons, taking more time to obtain their credits for graduation could make the difference between successfully completing high school or not. This persistence to graduation is referred to as "extended-time" graduation.

In 2016, 78% of Manitoba students graduated from high school on time, that is, within four years of entering Grade 9, up from 76% in 2013 (Figure 6.216). A larger proportion of young women graduated in four years (81%) compared to young men (76%) (Figure 6.216). The percentage that graduated within 6 years was 85% of young women and 81% of young men.

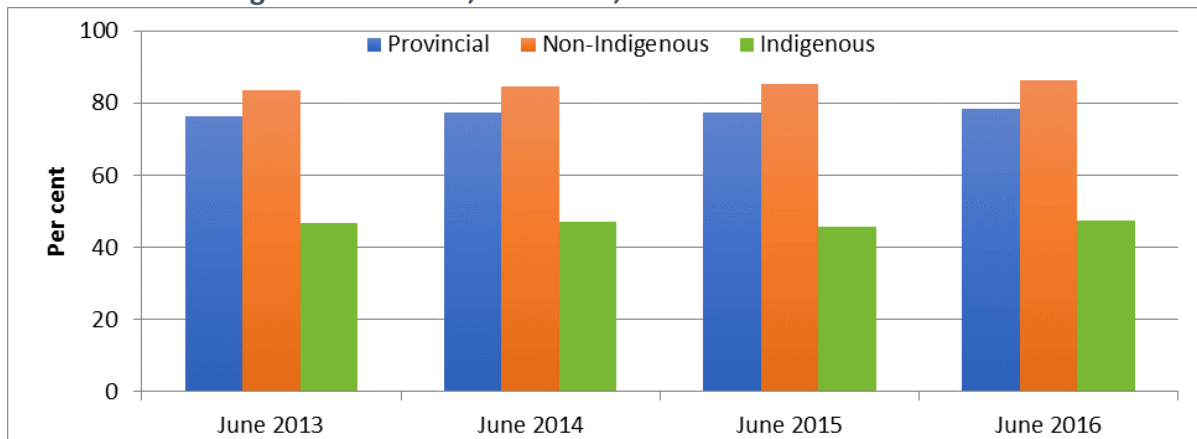
**Figure 6.216 Four-year student-tracked high school graduation rate, male and female students, Manitoba, June 2013 to June 2016**



Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/#student](http://www.edu.gov.mb.ca/k12/grad_rates/#student)

In 2016, 48% of Indigenous students graduated from high school after four years, which was relatively stable from 2013, compared to 86% of non-Indigenous students (Figure 6.217). 58% of Indigenous students graduated in six years.

**Figure 6.217 Four-year student-tracked high school graduation rate, Indigenous and non-Indigenous students, Manitoba, June 2013 to June 2016**

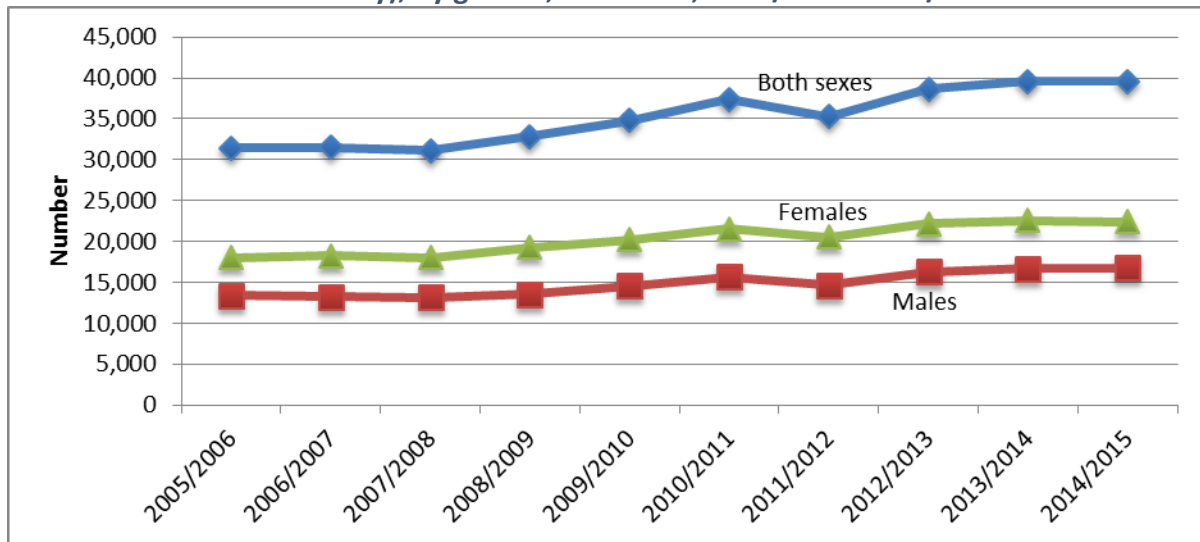


Source: Manitoba Education and Training. [http://www.edu.gov.mb.ca/k12/grad\\_rates/#student](http://www.edu.gov.mb.ca/k12/grad_rates/#student)

#### 6.4.9 Post-secondary Enrolment

In 2014/15, there were 39,549 youth under the age of 25 enrolled in post-secondary education, in colleges and universities, in Manitoba. Of those students, 57% were young women and 43% were young men. The number of young women enrolled increased by 26% between 2005/06 and 2014/15; the number of young men enrolled increased by 24% over the same time period (Figure 6.218).

**Figure 6.218** Number of youth under 25 years enrolled in post-secondary education (college and university), by gender, Manitoba, 2005/06 to 2014/15

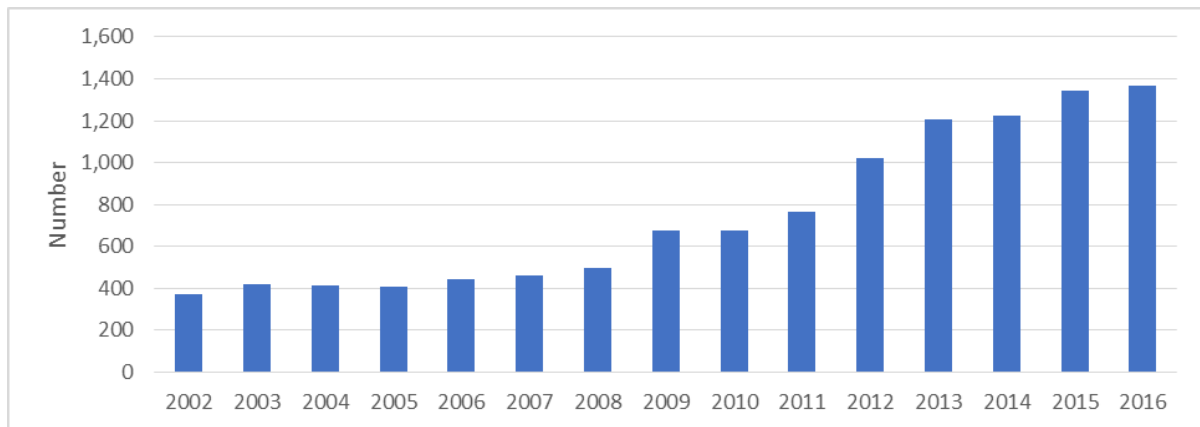


Source: Statistics Canada. Table 477-0033 - Post-secondary enrolments, by program type, credential type, age groups, registration status and sex, annual (number) (accessed: October 10, 2017)

#### 6.4.10 Home Schooling

In 2016/17, there were 1,365 students in Grades 7 to 12 being homeschooled in Manitoba, almost four times the number that were homeschooled in 2002 (Figure 6.219).

**Figure 6.219** Number of students who are homeschooled, Grades 7 to 12, Manitoba, 2002 to 2016



Source: Manitoba Education and Training, Provincial School Enrolment Annual Reports. [http://www.edu.gov.mb.ca/k12/finance/sch\\_enrol/index.html](http://www.edu.gov.mb.ca/k12/finance/sch_enrol/index.html)

#### 6.4.11 Cultural and Other Learning

Formal education is not the only kind of learning that prepares teens for their roles as adults. Gaining life skills, through learning to drive and taking on part-time employment, helps adolescents become more independent and responsible. Developing cultural knowledge, such as through spiritual practices, is also important, as it contributes to identity development and fosters feelings of connection to others.

Language is a foundational piece of culture. According to the 2008-10 Manitoba First Nations Regional Health Survey, 52% of First Nations youth ages 12 to 17 “understand or speak a First

Nation language.” However, only 30% of youth “use a First Nations language most often in daily life.” When asked how important it was “for you to learn a First Nations language,” most youth said it was important (84% of youth ages 12 to 14, and 87% of youth ages 15 to 17).<sup>283,284</sup>

### **Learning Indigenous Culture and History**

In Manitoba, Indigenous cultures and histories are taught mainly through the Social Studies curricula from K to 12 (mandatory at K to 11).

- Indigenous Peoples are an integral part of the development process of the land we now call Canada. Indigenous culture and history are deeply and authentically embedded throughout the curricula.
- Indigenous-related learning outcomes have been included for all students at each grade and are intended to help students develop knowledge and understanding of Indigenous culture and history. In addition, Indigenous student-specific learning outcomes are included in order to enhance the development of language, identity, culture and community for Indigenous learners.
- Treaty Education and Residential Schools education are part of this mandatory Social Studies curricula, with Residential Schools a focus at Grades 9 and 11 and Treaty Education a focus at Grades 5 and 6 in particular.

Other curricula, including science, English language arts and Kindergarten, include Indigenous perspectives and opportunities to study Indigenous cultures, history and ways of knowing as an “integratable” area that is on a priority level similar to Education for Sustainable Development and Information and Communications Technology.

Instruction, Curriculum and Assessment Branch, Manitoba Education and Training

## **6.5 Socially Engaged and Responsible**

During youth, relationships begin to change dramatically. As their own identity and self-esteem develops, so do youth social arrangements. Youth become increasingly autonomous, they may come into more conflicts with their parents, and the role of peers becomes more important. As their sexuality develops, they may have romantic or sexual relationships. Youth are also learning how to become socially responsible members of their family, community, and society.

### **6.5.1 Socially Engaged**

Positive relationships with family, friends, teachers, and people in the wider neighbourhood and community are important for healthy youth development.<sup>285,286</sup> Mentorship can play an important role in many aspects of adolescent learning and development, leading to improved grades, school attendance, and family relationships, and reduced likelihood of drug and alcohol initiation.<sup>287</sup>

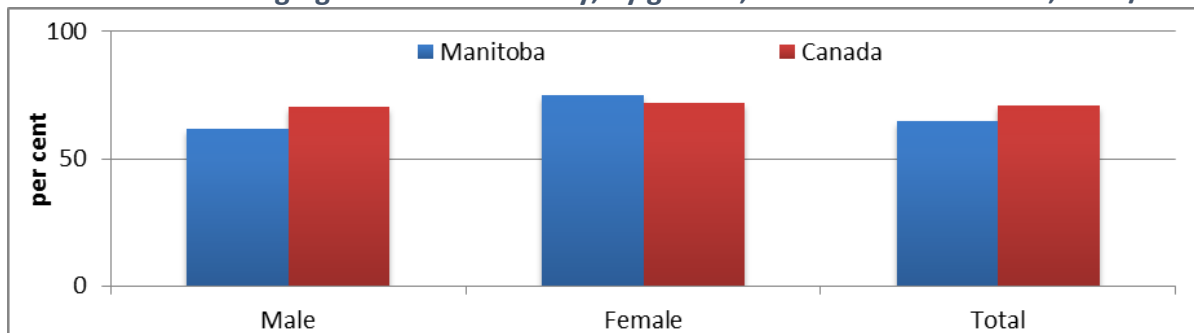
#### *6.5.1.1 Sense of belonging to community and school*

Youth engagement with communities and schools is important. Community engagement and feelings of community belonging are associated with better health.

In 2013/14, 65% of Manitoba youth aged 15 to 19 years reported that they had a somewhat or very strong sense of belonging to their community. That was lower than the rate for Canada overall (70%). The rates for young men (62%) were lower than those of young women (75%) in Manitoba (Figure 6.220). 15- to 17-year-olds were more likely to have a strong sense of belonging (72%) compared to 18- to 19-year-olds (62%). Since 2009/10, the sense of feeling a

very strong or somewhat strong sense of belonging has declined for young men aged 15 to 19 years in Manitoba from 73% to 62%.

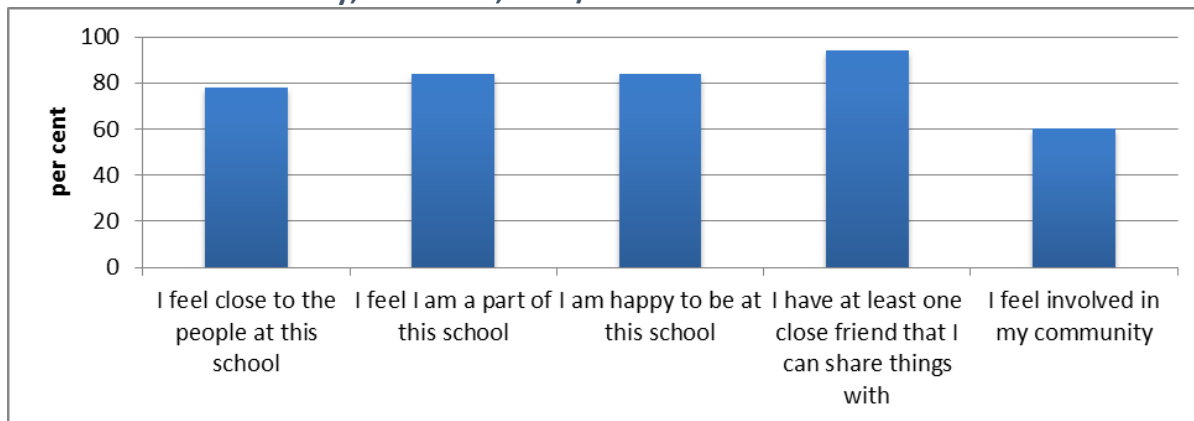
**Figure 6.220 Percentage of youth ages 15 to 19 with somewhat or very strong sense of belonging in their community, by gender, Manitoba and Canada, 2013/14**



Source: Canadian Community Health Survey 2013-2014 & 2011-2012 & 2009-2010, Public Use Data Set, Accessed through ODESI. The Canadian Community Health Survey does not include families living in First Nations Communities.

Studies have shown that feeling connected to one’s school is associated with better emotional well-being, and reduced suicidal and risky behaviours.<sup>288,289</sup> The majority of Manitoba students in Grades 9 to 12 feel that they belong at school: 84% felt they were a part of the school and were happy to be at the school and 78% said they felt close to the people at their school. The vast majority feel they have at least one close friend (94%). However, only 60% felt that they were involved in their community (Figure 6.221).

**Figure 6.221 Percentage of Grade 9 to 12 students who feel engaged at school and in their community, Manitoba, 2012/13**



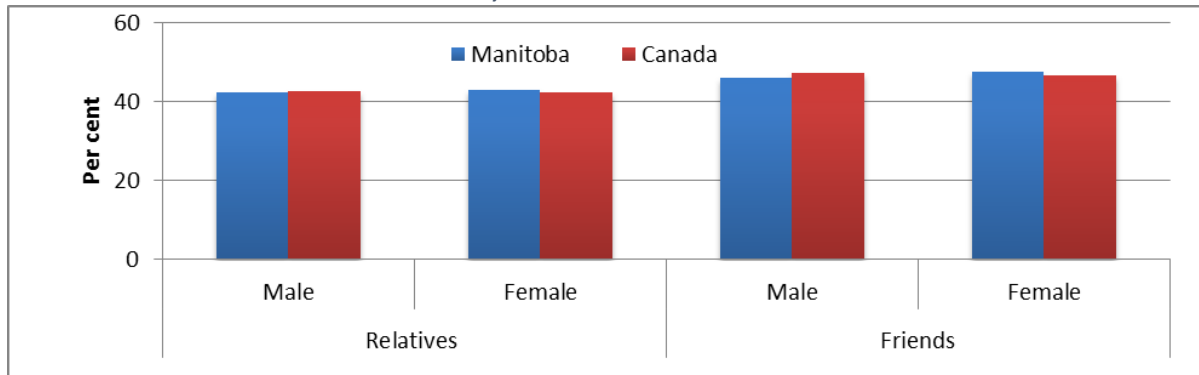
Source: Manitoba Youth Health Survey Report: 2012/2013. Partners in Planning for Healthy Living. 2014. Available: [http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report\\_FINAL.pdf](http://partners.healthincommon.ca/wp-content/uploads/2014/11/2012-13-Manitoba-YHS-Report_FINAL.pdf). Retrieved on August 19, 2017.

The majority of Manitoba students in Grades 9 to 12 generally felt that the adults in their school care about them and can be trusted: 83% felt that the adults at their school care about people their age, 79% felt that if they needed help, the adults at their school would help them, and 75% felt there was an adult at their school they could trust. Fewer (64%) would talk to a counsellor or other adult if they needed help.

In 2013, 46% of young men in Manitoba ages 15 to 24 were very satisfied or satisfied with their level of communication with friends, compared to 48% of young women (Figure 6.221), similar

to those for Canada overall. Young men and young women were both less satisfied with their communication with their relatives (Figure 6.222).

**Figure 6.222 Percentage of youth ages 15 to 24 who are very satisfied or satisfied with their level of communication with social networks, by gender, Manitoba and Canada, 2013**



Source: GSS, Cycle 27, Social Identity, 2013 [Public Use Microdata]. Obtained using ODESI.

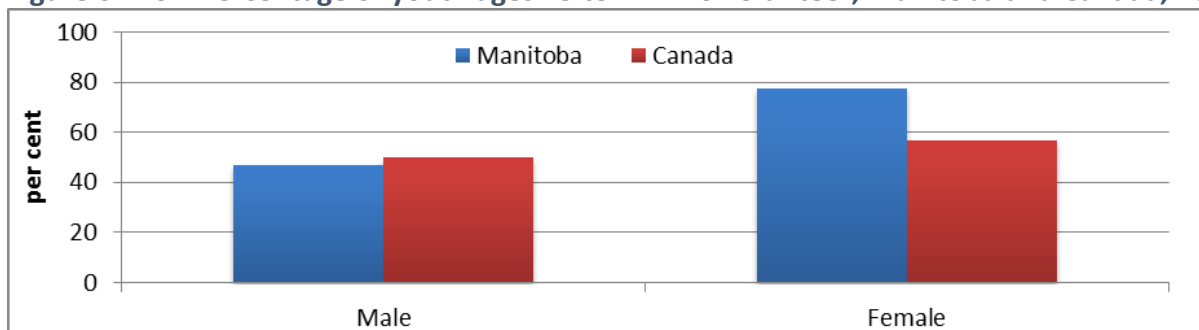
### 6.5.1.2 Community engagement

Community engagement takes many forms, but most often occurs through extracurricular activities and participation in community organizations, such as through volunteering. These activities are associated with better self-reported health and mental health (e.g., self-esteem, feelings of control), and less risk-taking behaviour (e.g., tobacco and marijuana use). However, it is important to note that adolescent participation in extracurricular activities and volunteering is also associated with more anxiety and feeling time-stressed.<sup>290</sup>

In the 2008/10 Regional Health Survey, two-thirds (66%) of First Nations youth ages 12 to 17 reported that they take part in their local community's cultural events. When asked about the importance of traditional cultural events in their life, over 80% of First Nations youth stated it was important.<sup>283</sup>

In 2013, 47% of young men in Manitoba reported that they had volunteered compared to 78% of young women. The proportion of young women in Manitoba who were volunteers was higher than for Canada overall, while the proportions were similar for young men (Figure 6.223). The proportion of young people volunteering increased between 2003 and 2014.

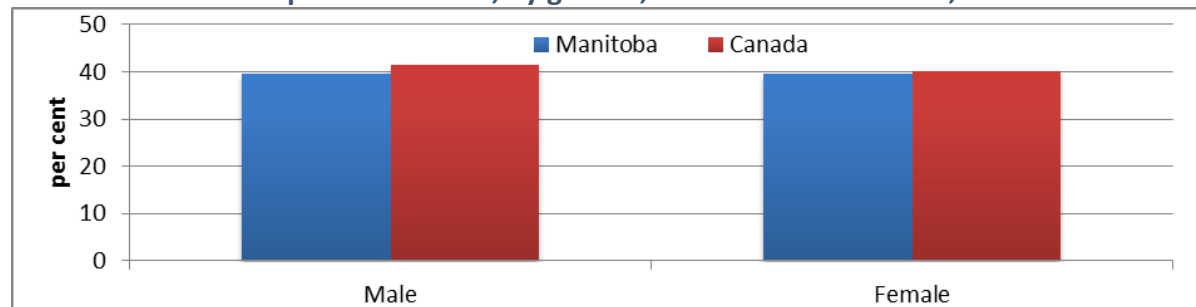
**Figure 6.223 Percentage of youth ages 15 to 24 who volunteer, Manitoba and Canada, 2013**



Source: General Social Survey (GSS), Cycle 27, Giving, Volunteering & Participating, Canada Survey of Giving, Volunteering and Participating, 2013 [Public Use Microdata]. Obtained using ODESI.

In Manitoba in 2013, 40% of both young women and young men ages 15 to 24 participated in an organized civic group in the previous 12 months. In Canada overall those rates were 42% for young men and 40% for young women (Figure 6.224).

**Figure 6.224 Percentage of youth ages 15 to 24 who participated in an organized civic group in the past 12 months, by gender, Manitoba and Canada, 2013**



Source: GSS, Cycle 27(2013), Giving, Volunteering & Participating, Canada Survey of Giving, Volunteering and Participating [Public Use Microdata]. Obtained using ODESI.

Note: 10 options given: political party/group, union, sports/recreation group, cultural/education group, religious group, school/civic group, service club, youth organization, immigrant/ethnic association, other.

Manitoba young men most frequently participated in sports/recreation (41%), culture/education (32%), faith-based (19%) and school/civic (14%) groups. For young women the most frequent groups were school/civic (41%), faith-based (33%), sports/recreation (31%) and culture/education (22%) groups.

## 6.5.2 Socially Responsible

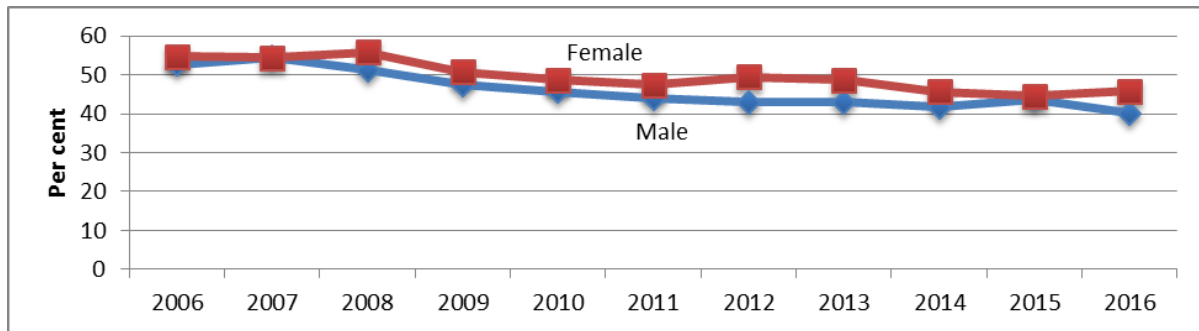
Behaving in a socially responsible way is a key learning task throughout childhood. In adolescence, increased responsibilities in the areas of sexual health, labour force participation, and planning for the future can lead to increased confidence and autonomy, but can also be a source of stress or insecurity. Consequences of socially irresponsible behaviour become more severe, particularly if that behaviour is against the law.

### 6.5.2.1 Employment

For many youth, participation in the labour force is a major step into the adult world of responsibility. Research has shown that positive work experiences are associated with leadership skills and career motivation. However, adolescents who work 20 hours per week or more also report higher levels of emotional distress.<sup>288</sup>

Employment rates of Manitoba youth aged 15 to 19 years have been steadily declining since 2006. In 2006, 53% of Manitoba men aged 15 to 19 were employed compared to 40% in 2016. Women age 15 to 19 employment trends were similar, with 55% employment in 2006, compared to 46% in 2016. Employment rates of Manitoba men and women aged 15 to 19 years have been declining for the most part every year since 2011 (Figure 6.225).

**Figure 6.225 Percentage of youth ages 15 to 19 who were employed, by gender, Manitoba, 2006 to 2016**

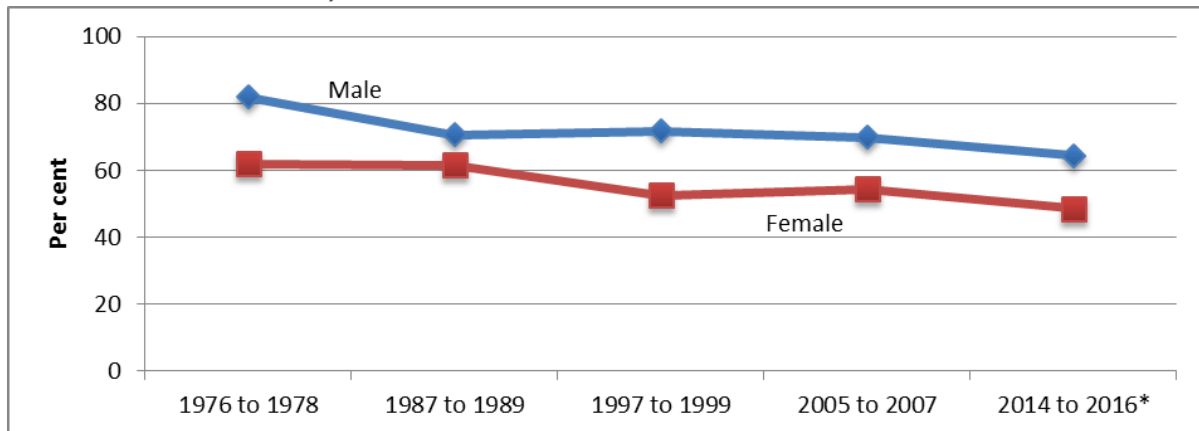


Source: Statistics Canada. CANSIM Table 282-0002 - Labour force survey estimates, by sex and detailed age group, annual (persons unless otherwise noted). Retrieved from <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=2820002>

Notes: Number of persons who, during the reference week, worked for pay or profit, or performed unpaid family work or had a job but were not at work due to own illness or disability, personal or family responsibilities, labour dispute, vacation, or other reason. Those persons on layoff and persons without work but who had a job to start at a definite date in the future are not considered employed. Estimates in thousands, rounded to the nearest hundred. The participation rate is the number of labour force participants expressed as a percentage of the population 15 years of age and over. The participation rate for a particular group (age, sex, marital status) is the number of labour force participants in that group expressed as a percentage of the population for that group. Estimates are percentages, rounded to the nearest tenth.

Between 2014 and 2016, 64% of Manitoba men and 49% of Manitoba women aged 17 to 24 years were employed full-time in their main job. The number of full-time employed 17- to 24-year-old men and women has been steadily declining since 1976 to 1978, when 82% of young men and 62% of young women were employed full-time (Figure 6.226).

**Figure 6.226 Per cent of youth ages 17 to 24 employed full-time in their main job, by gender, Manitoba, 1976 to 1978 to 2014 to 2016**



Source: Statistics Canada. Perspectives on the Youth Labour Market in Canada, 1976 to 2015. December 5, 2016. <http://www.statcan.gc.ca/daily-quotidien/161205/dq161205a-eng.pdf> (Accessed September 15, 2017)

\*Third quarter

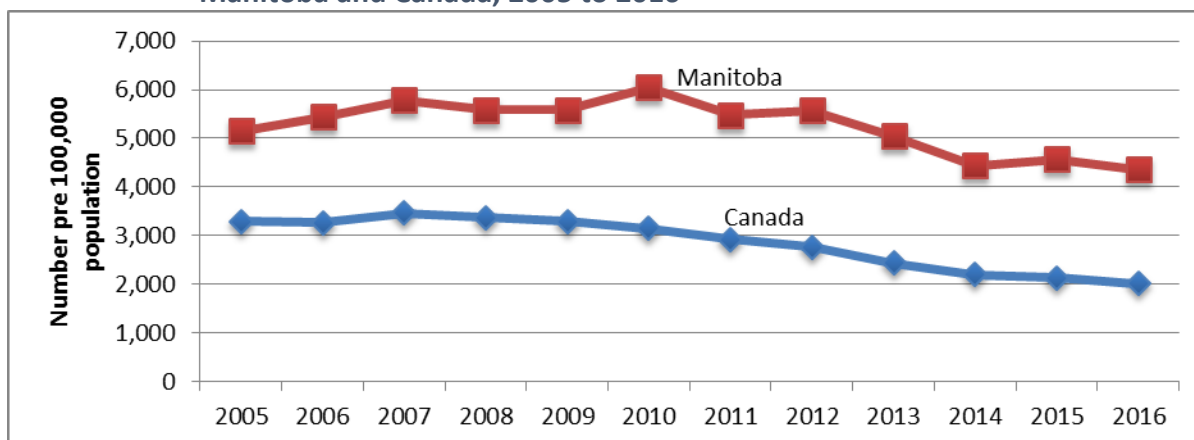
Note: Full-time students excluded

### 6.5.2.2 Youth crime

The youth crime rate is declining in Manitoba and in Canada overall. In 2016, the youth crime rate (12- to 17-year-olds) in Manitoba was 4,362 per 100,000 population, down from 5,147 in 2005. The Manitoba rate was twice the Canadian rate (Figure 6.227).



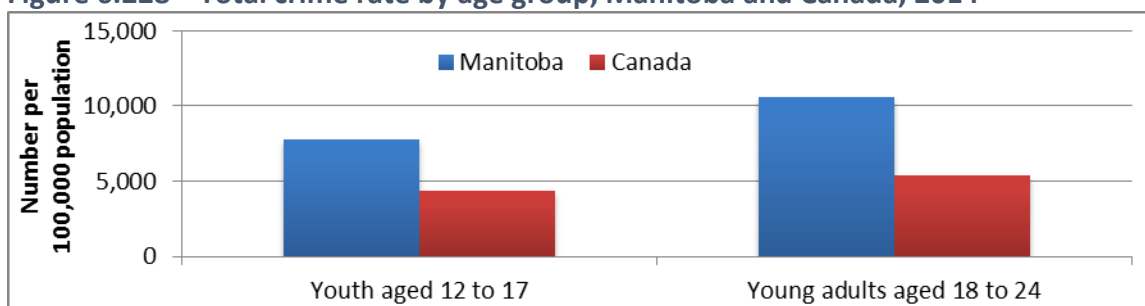
**Figure 6.227 Crime rate per 100,000 population, for youth ages 12 to 17, Manitoba and Canada, 2005 to 2016**



Source: Statistics Canada. CANSIM Table 252-0051 - Incident-based crime statistics, by detailed violations, annual (number unless otherwise noted). Retrieved from <http://www5.statcan.gc.ca/cansim/a47>

According to police reports, young adults aged 18 to 24 years have the highest crime rates compared to other age groups. In 2014, the Canadian rate of police-reported criminal offences (excluding traffic) was 5,428 per 100,000 18- to 24-year-olds. In Manitoba, that rate was 10,552 per 100,000 18- to 24-year-olds. The rates of criminal offenders was lower in other age groups. In Manitoba the rate was 7,798 per 100,000 among youth aged 12 to 17 (Figure 6.228).

**Figure 6.228 Total crime rate by age group, Manitoba and Canada, 2014**



Source: Allen M, Canadian Centre for Justice Statistics. 2016. Young adult offenders in Canada, 2014. <http://www.statcan.gc.ca/pub/85-002-x/2016001/article/14561-eng.pdf>

Between 2009 and 2014, the Canadian the rate of all individuals accused of crime by police fell 22%, with the overall rate for young adults declining by 31%. This drop was greatest among young adults aged 18 and 19 (-37%), age 12 to 17 (-39%) and the 20 to 24 age group (-24%).

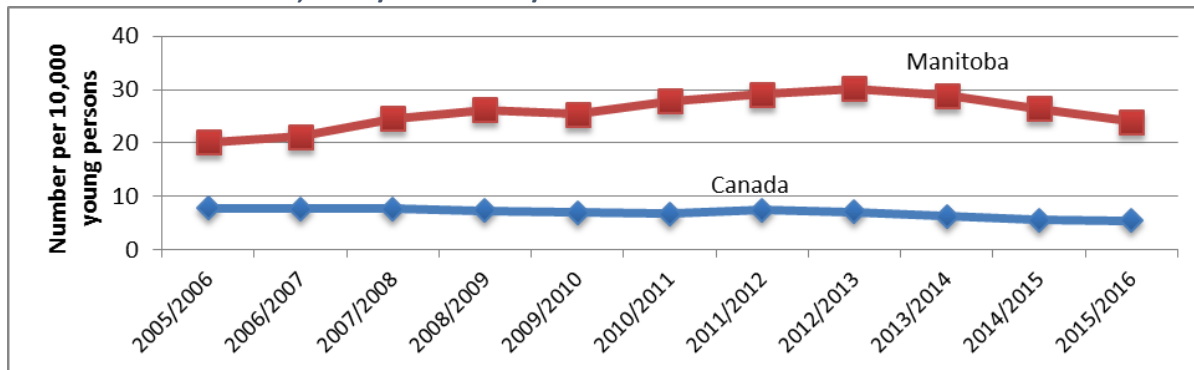
Criminologists have noted that vulnerable youth, particularly those who have experienced trauma, poverty, discrimination or abuse, are more likely to be arrested and charged with criminal behaviour.

The incarceration rate for Manitoba youth ages 12 to 17 is higher than it is for Canada overall. In 2005/06, the incarceration rate for Manitoba youth ages 12 to 17 was 20/10,000 young persons compared to 8/10,000 young persons in Canada overall. The rate in the Yukon was 29/10,000 and in Saskatchewan it was 19/10,000. All other provinces and territories had lower rates. Canada has seen a small but steady decline in their youth incarceration rate, from a high of 8/10,000 in 2005/06 to a low of 5/10,000 in 2015/16. Manitoba has fluctuated between a

low of 20/10,000 in 2005/06 to a high of 30/10,000 in 2012/13. The rate was back down to 24/10,000 in 2015/16.

In recent years the youth incarceration rate has been declining in Manitoba, but in 2015/16 it remains over 4 times the Canadian rate (Figure 6.229).

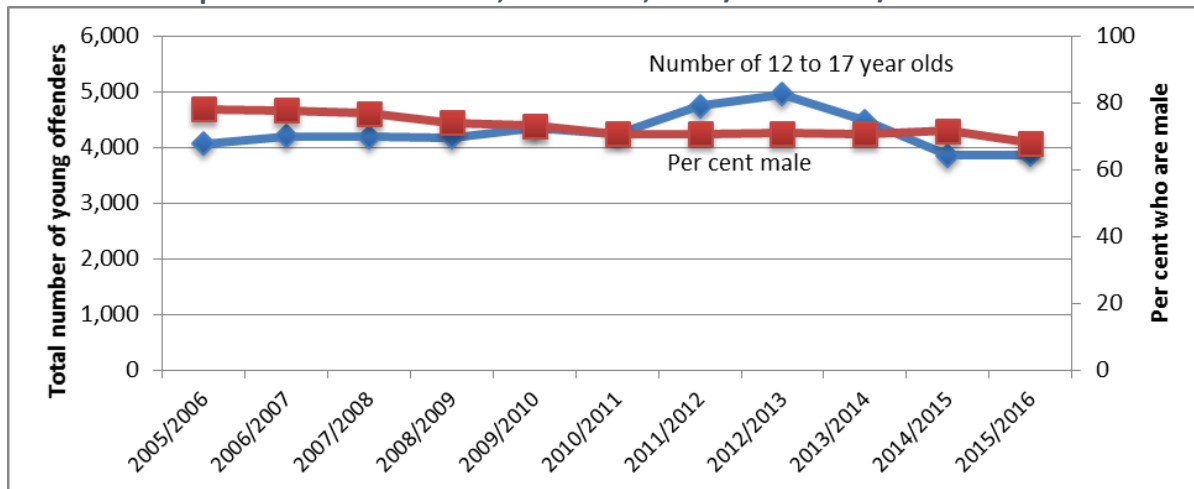
**Figure 6.229 Incarceration rate per 10,000 young persons ages 12 to 17, Manitoba and Canada, 2005/06 to 2015/16**



Source: Statistics Canada. Table 251-0008 Youth correctional services, average counts of youth in provincial and territorial correctional services, annual (persons unless otherwise noted)(1). Ottawa, ON: Statistics Canada.

The number of young offenders aged 12 to 17 who were admitted to correctional services in Manitoba increased from 2008/09 to 2012/13 but has declined since then. The per cent of young offenders admitted to correctional services who were male declined from 78% in 2005/06 to 68% in 2015/16 (Figure 6.230).

**Figure 6.230 Number of young offenders ages 12 to 17 admitted to correctional services and per cent who are male, Manitoba, 2005/06 to 2015/16**

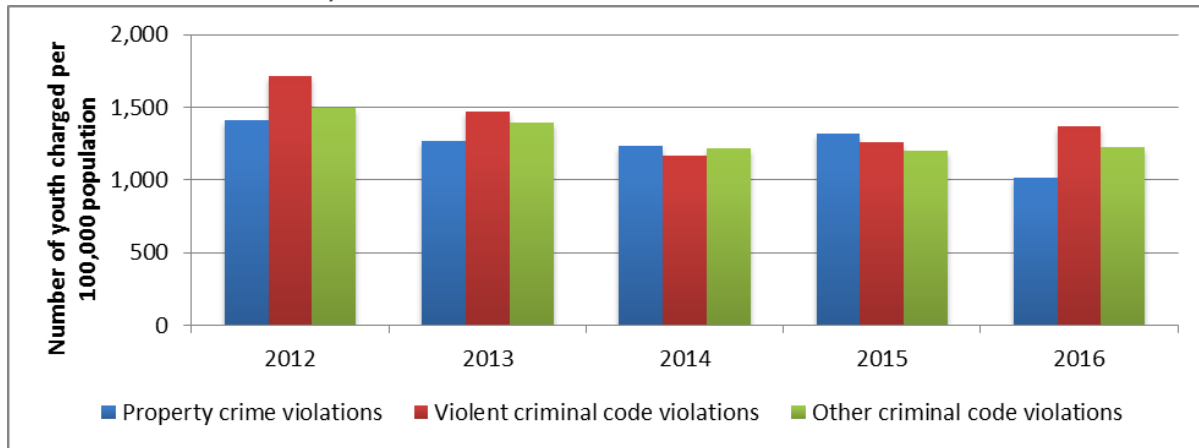


Source: Statistics Canada. Table 251-0011 - Youth custody and community services (YCCS), admissions to correctional services, by age and sex at time of admission, annual (number). (accessed: October 09, 2017). <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&idv=2510011&pattern=&stByVal=1&p1=1&p2=31&tabMode=dataTable&csid=>

The number of Manitoba youth ages 12 to 17 charged with property crime violations decreased from 1,414 (per 100,000 population) in 2012 to 1,012 in 2016. The rate of youth charged with 'other' violations also decreased during that time period. For violent crime, the rate declined

from 1,713/100,000 in 2012 to 1,216/100,000 in 2014. In 2015 and 2016, the rate increased to 1,372/100,000, still lower than 2012 (Figure 6.231).

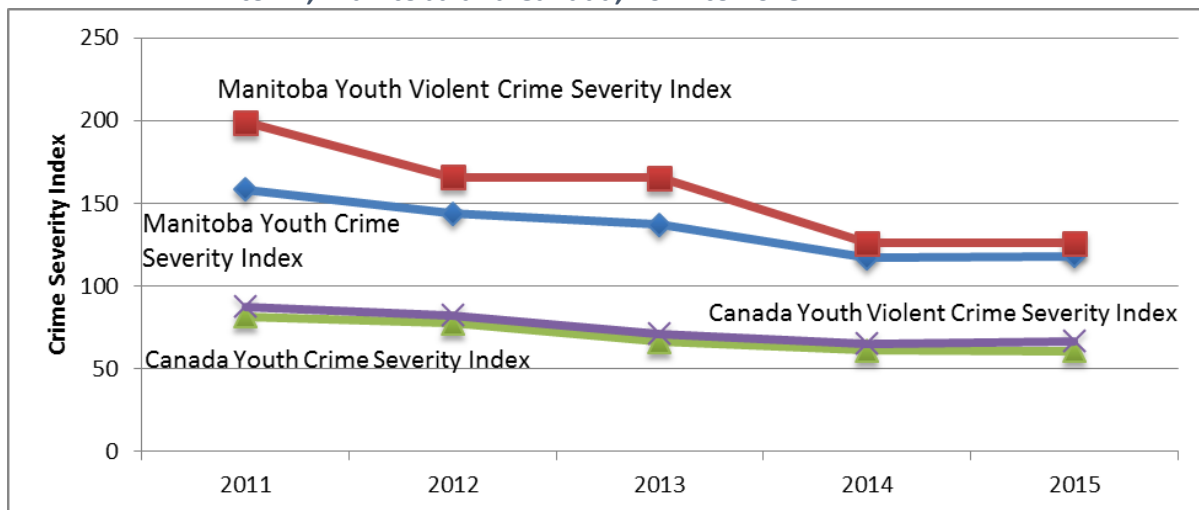
**Figure 6.231 Rate of youth crime per 100,000 population, by type of crime, ages 12 to 17, Manitoba, 2012 to 2016**



Source: Statistics Canada. Table 252-0051 - Incident-based crime statistics, by detailed violations, annual (accessed: October 09, 2017) <http://www5.statcan.gc.ca/cansim/a47>

The Youth Violent Crime Severity Index also saw a decline between 2011 and 2015 for both Manitoba and for Canada overall. The Manitoba Youth Violent Crime Index dropped 73 points between 2011 and 2014 and stayed at a similar level for 2015. However, Manitoba's Crime Severity Index remains almost double that of Canada overall (Figure 6.232).

**Figure 6.232 Youth Crime Severity Index and Youth Violent Crime Severity Index, youth ages 12 to 17, Manitoba and Canada, 2011 to 2015**



Source: Statistics Canada. CANSIM Table 252-0052 - Crime severity index and weighted clearance rates, annual (index unless otherwise noted). Retrieved from <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=2520052>

The Crime Severity Index is calculated using Incident-based Uniform Crime Reporting Survey (UCR2) data. The Crime Severity Index includes all Criminal Code violations including traffic, as well as drug violations and all Federal Statutes. The Police Reported Crime Severity Index measures changes in the level of severity of crime in Canada from year to year. In the index, all crimes are assigned a weight based on their seriousness. The level of seriousness is based on actual sentences handed down by the courts in all provinces and territories. More serious crimes are assigned higher weights, less serious offences lower weights. As a result, more serious offences have a greater impact on changes in the index. Per cent change represents the year-over-year (current year over last year) percentage change. The violent Crime Severity Index includes all Incident-based Uniform Crime Reporting Survey (UCR2) violent violations.

## 6.6 Summary

Youth is an important time of transition and transformation, when roles, relationships, and expectations change. Youth are expected to become more independent and responsible, while undergoing dramatic physical and emotional changes, with increased societal and peer pressure. Youth is also a time of exploration, where experiences and behaviours can have long-term effects that last into adulthood.

- In Manitoba, about two-thirds (63%) of youth (ages 15-19) self-rate their health as excellent or very good, lower than Canada (70%). More females (64%) than males (61%) reported their health as excellent or very good.
- Manitoba has one of the highest rates of Type 2 diabetes in children in the world, 12 times higher than any other province in Canada.
- The prevalence of attention deficit hyperactivity disorder (ADHD) in youth (ages 13-19) is on the rise. In the four-year time period 2009/10-2012/13 the prevalence was 4.8%. The prevalence is more than twice as high among boys compared to girls.
- The prevalence of Autism Spectrum Disorder (ASD) and other developmental disorders in youth (ages 13-19) is also on the rise. In 2009/10-2012/13 the ASD prevalence rate was 1.2%.
- Almost three-quarters of Manitoba 12- to 19-year-olds are physically active during their leisure time, similar to Canada.
  - As Manitoba youth get older, they are less likely to meet the recommended 60 minutes of daily physical activity, decreasing from 51% of Grade 7 students to 39% of Grade 12 students, and girls are less physically active than boys at each grade.
  - For Manitoba youth ages 12-24 years, physical activity varies between Indigenous groups: 62% of First Nations youth were moderately active or active (in the combined years 2011 to 2014). As were 66% of Métis youth, and 70% of non-Indigenous youth.
- Over half (54%) of Grade 9-12 students in Manitoba spend 3+ hours daily on screen time during the week, rising to two-thirds (67%) on weekends. Older students spend more screen time than do younger students.
- Overweight and obesity are on the rise. Two-thirds of boys and three-quarters of girls in Grades 9-12 have healthy weights.
- Only 14% of Manitoba Grade 9-12 students get the recommended 9 hours of sleep on school nights.
- Three percent of Manitoba Grade 7-12 students self-identify as being transgender and 5% have questioned their gender identity. Five percent of students reported being attracted to both males and females, and 2% reported being attracted to members of the same sex.
- Three-quarters (74%) of Manitoba Grade 7-12 students report that they have not had sex. This decreases as age increases: 96% in Grade 7 to 51% in Grade 12.
  - The most common age reported as the first time having sex was age 15 years (24%).
  - The most commonly used contraceptive was condoms (81%), while 13% reported not using any method of protection.
  - Of students reporting having sex, 17% reported having sex when they did not want to do so.

- While half (51%) of the students were comfortable discussing contraception with their partners, over a third (37%) reported having unplanned sex after using alcohol or drugs during the past year.
- Manitoba youth (ages 15-19) continue to have high rates of sexually transmitted infections (STIs). Between 2012 and 2016, the most commonly reported STIs were chlamydia and gonorrhoea. The rate of chlamydia among Manitoba youth ages 15 to 19 was 1,947 per 100,000 population in 2016. The rate had declined from 2012 to 2014, and then increased again in 2016. The rate of gonorrhoea among Manitoba youth ages 15 to 19 was 539 per 100,000 population in 2016. That was up 35% from 2012, when it was 398 per 100,000 population.
- Three in four (74%) Manitoba youth (ages 15-17) self-report their mental health as excellent or very good, declining to two-thirds (62%) for young men at ages 18-19, but stable (75%) for young women.
  - In Manitoba, around half of First Nations and Métis youth (ages 18-24) self-report their mental health as excellent or very good. 53% First Nations males and 49% First Nations females report their mental health as excellent or very good, as do 59% Métis males and 56% Métis females).
  - Almost half of Grades 9-12 students are at risk for future mental health problems.
  - In Manitoba, 24% of young women and 16% of young men (ages 15-19) report significant levels of stress in their lives.
  - Fewer Manitoba First Nations and Métis youth (ages 15-24) report stress than their counterparts in Canada, and than non-Indigenous youth in Manitoba and Canada.
- Since 2003, youth smoking in Manitoba has dropped by half, from 14% to 7% (in 2014), similar to Canada. Over half of Manitoba youth smokers do so daily.
  - Smoking is more common among Manitoba's First Nations (35%) and Métis (27%) youth ages 12-24, (in 2011/14)
- In the past month, half of Manitoba Grade 12 students report having at least one alcoholic drink, 38% drank on 1 to 5 days, and 12% drank 6 or more days per week.
  - Alcohol use increases by age: 17% of Grade 9 students and 50% of Grade 12 students have had at least one drink in the past month.
  - One in eight Grade 12 students reported drinking and driving.
- In Manitoba, over a third of Grade 11-12 students have used recreational or prescription drugs to get high in the past year. The rates were similar for males and females, 37% males and 34% females in Grade 12. This increases with age, from approximately one in five Grade 9 students.
  - One in five Grade 7-12 students use marijuana/hashish to get high.
- Mood and anxiety disorders in youth (ages 13-19) are on the rise, particularly for girls.
  - In Manitoba, nearly 4 times as many 15- to 17-year-old girls (15%) report major depression, compared to boys (4%). These rates higher compared with Canada overall.
- In Manitoba, suicide is the leading cause of injury deaths (intentional and unintentional) in children ages 10 and up. The suicide rate is stable at 74/100,000 for 13- to 19-year-olds.
  - Girls are more likely to complete suicide than boys.
  - Suicide deaths are associated with prior inconsistent school attendance, hospitalization for suspicious injuries, criminal justice system involvement, documented suicidal ideation, parental and youth substance abuse, and frequent placement moves.

- For Manitoba First Nations youth (ages 15-24), the suicide rates are 5 times higher for boys and 7 times higher for girls, compared to the national average.
- Almost one in five youth (ages 12-17) in First Nations communities have contemplated suicide, and one in ten (10%) have attempted suicide at least once.
- Across Manitoba, 3 times as many girls (ages 13-19) have attempted suicide, compared to boys. Suicide attempts are more prevalent in rural/northern (vs. urban) and lower-income (vs. higher-income) communities.
- Youth (ages 15-19) injury hospitalization rates are decreasing over time. Motor vehicle collisions are the leading cause of unintentional injury hospitalization.
- Youth mobile crisis calls and crisis stabilization unit admissions may be on the rise across Manitoba. Over the past 18 years, youth psychiatric consultations in the Children’s Hospital emergency department have quintupled.
- Compared to young men, young women (ages 15-24) report higher rates of dating violence, twice as high in Manitoba (16% for controlling/emotional abuse and 10% for physical/sexual abuse) than Canada (7% and 5%, respectively).
  - In Manitoba, these rates are similarly higher for Indigenous youth, compared to non-Indigenous youth, and higher than Canada. (In 2014, 12% of Indigenous youth age 15 to 24 reported being victims of emotional abuse in a relationship, and 8% reported experiencing physical/sexual abuse.)
- In both Manitoba and Canada, one in four (26% in Manitoba and 27% in Canada) youth (ages 15-24) is a victim of crime (excluding spousal or dating violence).
- In Manitoba, 3 times as many Indigenous youth (ages 15-24) witnessed family violence before age 15 (14%), compared to non-Indigenous youth (4%).
- The majority of Manitoba Grade 9-12 students feel safe in their home (98%), school (90%), and community (88%).
  - However, the majority of transgender and gender diverse youth in Manitoba feel unsafe at school (64%). Many experience harassment, bullying, and sexual assault.
- More than a third (39%) of all Manitoba Grade 9-12 students have been body-shamed or bullied, taunted, or ridiculed.
  - One in four have been physically threatened/injured (27%) or subjected to racism (23%).
  - Girls are more likely to be socially or cyberbullied than boys, whereas boys are more likely to be physically bullied. While verbal, social, and physical bullying all decline with age, cyberbullying remains steady from Grades 7-12 in Manitoba.
- Manitoba 18- and 19-year-old youth represent nearly 3% of all people on Employment and Income Assistance (EIA). Youth on EIA represent 5% of all youth in Manitoba.
- Over 3,000 youth (ages 13-18) live in subsidized housing. One in ten (10%) Manitoba youth (ages 15-29) live in core housing need, with higher rates for First Nations, Métis, and Inuit peoples. (34% of Manitoba Status Indians, 24% of non-Status Indians, 21% Inuit and 15% Métis.)
- More than a quarter (1,400 - 27%) of Winnipeg homeless people are youth (ages 16-29): the majority are Indigenous and have spent time in Child and Family Services (CFS).
- Since 2006, nearly 13 times as many permanent youth wards of CFS have received support from age 18 to 21, that is beyond termination of guardianship. 917 youth received this support in 2017.

- The majority of Manitoba Grade 9 students attain a Mathematics credit (88%) and English Language Arts credit (90%) by the end of the year. 93% and 94% of non-Indigenous and 69% and 74% of Indigenous students, respectively, achieve this credit.
- Average marks for Manitoba Grade 12 provincial exams have been stable over the past decade: between 50%-60% for applied or essential mathematics, between 60%-70% for pre-calculus mathematics, between 60%-70% for language arts. The average marks are slightly higher for French in Français and French Immersion programs.
- In 2015, on the international PISA exams\* (\*Organisation for Economic Co-operation and Development (OECD) Programme for International Student Assessment (PISA)), 83% of Manitoba 15-year-olds performed at the baseline level of science proficiency, compared to 89% in Canada and 79% across OECD countries.
  - On PISA reading literacy, Manitoba youth scored higher than the OECD average but lower than the Canadian average, with girls doing better than boys.
  - On PISA mathematics literacy, Manitoba scored lower than both the OECD and Canadian averages, with girls and boys doing similarly.
- In 2016, 78% of all Manitoba students graduated from high school “on time” (within four years of entering Grade 9); this reflects 81% of girls, 76% of boys, 86% of non-Indigenous students, and 48% of Indigenous students.
- In 2014/15, nearly 40,000 Manitoba youth under age 25 (57% were female and 43% were male) were enrolled in post-secondary education.
  - Over the past decade, female enrolments increased by 26% and male enrolments by 24%.
- Over half of Manitoba First Nations youth (ages 12-17) understand or speak a First Nations language.
- Most Manitoba Grade 9-12 students feel they belong at school (84%) and have at least one close friend (94%).
  - Most feel the adults at school care about them and can be trusted (75%-83%), but fewer (64%) would talk to a counsellor or other adult if they needed help.
- About half of Manitoba youth (ages 15-24) feel satisfied with their level of communication with friends or relatives. The rates are similar between young men (46%) and women (48%).
- In Manitoba, two-thirds (66%) of First Nations youth (ages 12-17) participate in local community cultural events.
- One in two (47%) Manitoba young men and four in five (78%) Manitoba young women (ages 15-24) volunteer, similar to and higher than Canada, respectively.
- Manitoba youth employment rates (ages 15-19) have been steadily declining over the past decade, for both males and females. (Males dropped from 53% to 40%, females decreased from 55% to 46%) For ages 17-24 years, 64% of men and 49% of women in Manitoba were employed full-time, rates that have steadily declined over the past four decades from 82% and 62%, respectively.
- Over the past decade, youth crime rate has declined in both Manitoba and Canada, with the Manitoba rate (4,362 per 100,000) twice as high as the Canadian rate. The Manitoba youth (age 12-17) incarceration rate is up to 4 times as high as the Canadian rate.



## Appendix A

### 7.1 Indicator and Data Selection Criteria and Guiding Principles

The 2017 Child and Youth Report Interdepartmental Working Group (CYRIWG) oversaw the development of this report. The CYRIWG is made up of experts from Manitoba Government Healthy Child Committee of Cabinet departments responsible for the health and well-being of Manitoba children, youth and families.

### 7.2 Indicator Selection Criteria

When choosing indicators it was important to ensure that they are *meaningful* and suit the *intended purpose*. Taking into account criteria used in a number of children's indicator reports, the following criteria was used to help select indicators for the 2017 HCMO CYR:

1. Indicators could be quantitative (based on data/statistics) or qualitative (based on narratives, focus groups, individual interviews, participation/observations etc.).
2. Indicators could be observed (objective) or self-reported (subjective).
3. Indicators could be positive or negative (both positive and negative data/information is important to present when reporting on an issue).
4. Indicators should represent:
  - determinants of children's health and well-being, that is, what influences health and well-being
  - health, education, social outcomes, or how children are doing
5. Indicators should be obtained through an open, transparent and democratic consultative review process.
6. Indicators should be directly relevant to the target audiences and contribute to a coherent and comprehensive view of children's health and well-being.
7. Indicators should be credible with both the indicators and their underlying data being unbiased and coming from reliable and scientifically valid sources.
8. Indicators should be responsive and sufficiently sensitive to signal positive or negative changes in a timely fashion as well as providing early warning of problems wherever possible. Indicators can only be responsive however, if data are easy to obtain, regularly updated and available over time.
9. Indicator data should be feasible to obtain with data needed to populate indicators available or if not, accessing/purchasing data should be technically and financially feasible.

### 7.3 The Data Selection Process

Information in the Child and Youth Report comes from traditional sources such as census data, vital statistics, and hospitalization data. It also comes from population-based national and provincial surveys, provincial reports and peer-reviewed research findings. When selecting data sources, the following criteria was applied to ensure the highest quality of data was utilized:

1. The data should be population-based (national, provincial and population specific).
2. The data should be current (as determined by the CYRIWG) or earlier unless trend data is being presented.
3. The indicators should be described either based on primary analysis of a population-based data source or from published sources (based on population-based data).

4. The data should be presented nationally, provincially and sub-provincially (regionally) wherever possible.
5. The data should be presented by age group, gender, Indigenous identity, ethnicity and geography wherever possible.
6. If data do not exist nationally or by province, but research has been published in a peer-reviewed journal to describe an important issue, this information could be presented. It will be made clear what the source of the information is and what it represents.
7. If data do not exist nationally, by province, by Manitoba region, or from published/peer-reviewed research to describe an issue that is deemed important by the experts, this information could be presented as a gap in information.

## **7.4 Important Manitoba Data Sources**

In Manitoba, there are a number of excellent data reports written by government departments and outside agencies such as the Manitoba Centre for Health Policy. Below please find links to where the original source reports can be found. These provide additional information about the health of Manitobans. In many cases, the data is broken down by the different Regional Health Authorities or presented at a community level to provide even more detail. Please explore the links listed below for more information.

### **7.4.1 Manitoba Government Reports**

- Healthy Child Manitoba Office: <https://www.gov.mb.ca/healthychild/>
- Manitoba Families (Annual Reports): [https://www.gov.mb.ca/fs/about/annual\\_reports.html](https://www.gov.mb.ca/fs/about/annual_reports.html)
- Manitoba Health, Seniors and Active Living (Annual Reports): <https://www.gov.mb.ca/health/ann/index.html>
- Manitoba Education and Training (Graduation rates): [http://www.edu.gov.mb.ca/k12/grad\\_rates/index.html](http://www.edu.gov.mb.ca/k12/grad_rates/index.html)
- Manitoba Justice (Annual Reports): <https://www.gov.mb.ca/justice/publications/annualreports/index.html>

### **7.4.2 The Manitoba Centre for Health Policy**

MCHP is a research unit within the Department of Community Health Sciences at the University of Manitoba, focusing on the question “What makes people healthy?” Since 2005, Manitoba’s Healthy Child Committee of Cabinet has commissioned a research deliverable every year from MCHP to delve into questions of child and youth health and well-being. Previous HCCC-commissioned MCHP deliverables have included research on child and youth mental health, educational outcomes of children in care, early childhood impacts on school readiness, as well as rigorous evaluations of Healthy Child Manitoba Office programs, such as Families First, Healthy Baby and InSight. MCHP produces numerous reports on the health and well-being of Manitobans.

<http://mchp-appserv.cpe.umanitoba.ca/deliverablesList.html>

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