

FEDERAL/PROVINCIAL/TERRITORIAL
EARLY CHILDHOOD DEVELOPMENT AGREEMENT

THE WELL-BEING OF CANADA'S
YOUNG CHILDREN:

GOVERNMENT OF CANADA REPORT
2002



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PREFACE



In September 2000, the Government of Canada and provincial and territorial governments¹ reached an historic agreement to improve and expand the services and programs they provide for children under 6 years of age and their families. In the Federal/Provincial/Territorial Early Childhood Development Agreement, Canada's First Ministers committed to help young children reach their potential, and to help families and the communities in which they live support their children.

Under the Agreement, governments have committed to report regularly to Canadians on outcome indicators of young children's well-being. Governments have identified a common set of 11 indicators of well-being which will provide valuable information on the physical health and early development of young children in Canada.

This document is the Government of Canada's fulfillment of the commitment to report on the well-being of Canada's young children.

This report expands upon the common set of 11 indicators to provide a portrait of children from birth to 5 years of age in Canada, including information on physical health, safety and security, and early development. In addition, this report provides an overview of the families in which young Canadian children are growing up. The data presented in this report are for 1998-1999, establishing a baseline against which the indicators can be tracked in the future.

The Government of Canada will strive to improve the quality of reporting over time.

As part of their commitment to public reporting in the Early Childhood Development Agreement, governments also agreed to report annually to Canadians on their progress in enhancing early childhood development programs and services.

As a complement to the information in this report, the reader may wish to refer to *Early Childhood Development Activities and Expenditures: Government of Canada Report 2001-2002*, which provides information on the progress the Government of Canada has made in enhancing early childhood development programs and services since the Agreement was put into place.

¹ The Government of Quebec has stated that while sharing the same concerns as other governments on early childhood development, it does not adhere to the Federal/Provincial/Territorial Early Childhood Development Agreement. The Government of Quebec is receiving its share of funding from the Government of Canada for early childhood development programs and services through the Canada Health and Social Transfer (CHST).



Chapter 1: INTRODUCTION



Background

The Early Childhood Development Agreement

In September 2000, the Government of Canada, in partnership with provincial and territorial governments (except the Government of Quebec), reached an historic agreement to improve and expand the services and programs they provide for children under the age of 6 and their families. The Early Childhood Development Agreement is a long-term commitment to help young children reach their full potential, and to help families support their children.

As part of this agreement, governments committed to keeping the public apprised of progress in the area of early childhood development. Specifically, First Ministers committed to report on investments in early childhood development programs and services as well as on child outcomes.

Beginning in the fall of 2002, each participating government will report annually on its progress in improving and expanding early childhood development programs and services under the Agreement. The Government of Canada's report *Early Childhood Development Activities and Expenditures: Government of Canada Report 2001-2002* was released recently in fulfillment of this commitment (this report is available at www.socialunion.gc.ca, by calling 1 800 O-CANADA (1 800 662-6232) or by TTY at 1 800 465-7735).

Also, in the fall of 2002, participating governments will begin regular reporting on child well-being. Reporting on child well-being will help build public awareness of how young children are faring in Canada, as well as demonstrate governments' commitment to meeting the objectives of the Early Childhood Development Agreement. This report is the Government of Canada's first step in fulfillment of this commitment.

The National Children's Agenda – A Shared Vision for Canada's Children

In 1999, the Government of Canada, in partnership with provincial and territorial governments, began work on a National Children's Agenda (NCA), which sets out a shared vision for Canada's children. This common vision includes wanting our children to be loved and to thrive; to be valued; to develop their unique physical, emotional, intellectual, spiritual and creative capacities; to be respected and protected and, in turn, to respect and protect the rights of others; and to belong and contribute to communities that appreciate diversity, support different abilities and share their resources.

The NCA shared vision also outlined values and goals for Canadian children, along with six policy areas in which governments could cooperate to better support children. Enhancing early childhood development was one of these areas that governments chose to act on.

Reporting on Child Outcomes

In Canada, there is a growing consensus on the importance of the early years. What happens to children from conception to age 5 sets the stage for how they will fare in the future in all aspects of their lives. It is important to monitor and track information on children's well-being and development to help build awareness and understanding of how children in Canada are doing. Ongoing monitoring can offer "warning signals" about areas where children require greater support, as well as highlight positive outcomes. In so doing, it provides a powerful tool to inform and improve policy making to ensure that the actions of governments, and others, are as focused and effective as possible.

A Framework for Monitoring Child Well-Being

What Is "Child Well-Being"?

"The early years of life are critical in the development and future well-being of the child, establishing the foundation for competence and coping skills that will affect learning, behaviour and health."² One of the commonly used approaches to define well-being incorporates a framework consisting of five domains: physical health and motor development; emotional health; social knowledge and competence; cognitive learning; and language communication.

The Five Domains of Child Well-Being³

Physical Health and Motor Development:

The child's general state of health and gross and fine motor skills.

Emotional Health:

The child's self-esteem, coping skills and overall emotional well-being.

Social Knowledge and Competence:

The way a child behaves and is able to communicate feelings and wants.

Cognitive Learning:

The ways in which a child perceives, organizes and analyzes information provided by his or her social and physical environment.

Language Communication:

The ability of a child to communicate, including receptive and expressive language skills.

² First Ministers' Communiqué on Early Childhood Development, September 2000.

³ Adapted from: Doherty, Gillian (May 1997) *Zero to Six – The Basis for School Readiness*. Applied Research Branch Paper No. R-97-8E. Ottawa: Human Resources Development Canada.

Environmental Influences on Child Well-Being

Children are shaped by the world around them, and many environments affect their development. It is generally accepted that “healthy children emerge most often from healthy families, and healthy families are in turn promoted by healthy communities.”⁴ Understanding the key factors that influence child development can help society make choices that build supportive environments for children.

The NCA shared vision identifies five key environmental influences that affect children's development: biological inheritance; family; child care and school; physical and community environments; and society.

Key among these influences is family. Parents are the primary support for children and have a critical role in shaping how a child develops. Each child is born with a particular set of characteristics inherited from his or her parents that can influence the child's well-being in all five domains. And, it is within the family environment that the majority of children spend their formative years and where much of their development occurs.

Families are shaped by the physical and community environments in which they live. Communities provide the basic infrastructure for family life, including housing, education and employment. Physical surroundings can greatly affect children's health and well-being, and research is beginning to provide evidence that growing up in a community that is perceived to have higher levels of cohesion, stability and social supports will lead to healthier child development.

How Are Governments Reporting on Young Children's Development?

The Government of Canada has been working in partnership with provincial/territorial governments, and with communities, to improve child well-being. The NCA, National Child Benefit and the Federal/Provincial/Territorial Early Childhood Development Agreement are examples of governments' commitment to work collaboratively on issues related to children. As part of this commitment, governments have recognized the importance of regularly monitoring and reporting on young children's well-being as a means of helping inform policy making and of building public awareness and understanding. In the September 2000 Early Childhood Development Agreement, First Ministers committed to “*make regular public reports on outcome indicators of child well-being using an agreed upon set of common indicators....related to the objectives established for early childhood development.*”

In determining which indicators to report on, governments tried to address all five of the domains of well-being in order to paint as complete a picture of child well-being as possible. Governments looked at which indicators were recognized both nationally and internationally as key indicators of child well-being, while remaining cognizant of what data were available at the national and provincial/territorial levels in Canada. Considerations also included ensuring that the indicators were meaningful to the public, and would enhance knowledge of child well-being,

⁴ Ross, David P., Scott, Katherine and Kelly, Mark A. (1996) “Overview: Children in Canada in the 1990s” in *Growing Up in Canada – National Longitudinal Survey of Children and Youth*. Ottawa: Human Resources Development Canada/Statistics Canada.

without duplicating reporting currently being done by others (e.g. non-governmental organizations and researchers). Experts were consulted to ensure that the indicators selected were both meaningful and methodologically sound.

Governments agreed to report, at a minimum, on a common set of 11 indicators of child outcomes. They also agreed to release their reports in the fall of 2002. Through this reporting, Canadians will be able to develop a better understanding of the situation of young children in Canada. Release of these reports by all participating governments will mark the first time that governments are reporting to the public on a set of jointly agreed indicators of child well-being.

The Early Childhood Development Agreement – Common Indicators of Young Children's Well-Being	
<p>Physical Health and Motor Development</p> <ul style="list-style-type: none"> • Healthy Birthweight • Incidence of Meningococcal Group C Disease • Incidence of Measles • Incidence of Haemophilus Influenzae–b (Hib) • Infant Mortality Rate • Motor and Social Development 	<p>Emotional Health</p> <ul style="list-style-type: none"> • Emotional Problem-Anxiety • Hyperactivity-Inattention • Physical Aggression-Conduct Problem <p>Social Knowledge and Competence</p> <ul style="list-style-type: none"> • Prosocial Behaviour <p>Cognitive Learning and Language Communication</p> <ul style="list-style-type: none"> • Language

Format of the Report

The objective of this Government of Canada report is to help foster an understanding of young children in Canada and their families. In order to do this, the report focuses on the 11 indicators of well-being for young children identified by federal/provincial/territorial governments, supplemented by additional indicators of children's physical health as well as measures of key family and community influences on child well-being.

The second chapter, "A Portrait of Canada's Young Children," presents indicators related to the five domains of child well-being: physical health and motor development, emotional health, social knowledge and competence, cognitive learning and language communication. The section begins by contextualizing who Canada's young children are, followed by information on their health, safety and security, and early development.

The third chapter, "A Portrait of Canadian Families," presents key information on the context in which young children are growing up. Specifically, this chapter discusses the kind of families young Canadian children are growing up in, their parents and the interaction between children and parents.

Currently, there are little data available on young Aboriginal children. The fourth chapter presents an overview of the information known about young Aboriginal children. The chapter also highlights where information gaps exist and describes potential future sources of data. It is hoped that future reports will be able to provide more thorough information about Aboriginal children.

In addition, there is little data available on young children with disabilities. The fifth chapter presents a summary discussion of what is known about young children with disabilities. Through new data sources it is hoped that future reports will be able to provide more thorough information about children with disabilities.

Chapter 6 provides a summary table of the indicators of young children's well-being and family and community-related measures discussed in Chapters 2 and 3 of the report. Those indicators denoted by an asterisk (*) are part of the common set of 11 indicators agreed to by federal/provincial/territorial governments.

Annex A contains a list of the acronyms used throughout the report.

Sources of Data

Measuring the well-being of children is a challenging task. Children grow and develop rapidly from birth to age 5, so that a measure of well-being that may be appropriate at one age is not appropriate a year earlier or a year later. Children develop across a broad range of abilities and traits which no single indicator can capture. Consequently, the indicators presented in this report cover a range of domains of child development. In some cases, these indicators are appropriate for one age group of children only, in other cases they apply to all children from birth to 5 years old. Together, the indicators provide a broad view of how young Canadian children are doing.

While it is not yet possible to measure all aspects of child well-being or all of the factors that influence well-being, great progress has been made over the past years in expanding data collection in this area. There is a long established tradition of data collection on health issues in Canada. In particular, the Vital Statistics registry is an important source of information on the physical health of young children. The Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP) provides valuable information on injuries and hospitalizations. In addition, the census provides descriptive information on young children and their families. Two postcensal surveys, the Participation and Activity Limitation Survey (PALS)⁵ and the children's component of the Aboriginal Peoples Survey (APS)⁶ are likely to be sources for information in the future.⁷

⁵ The first release of the PALS is scheduled for 2003.

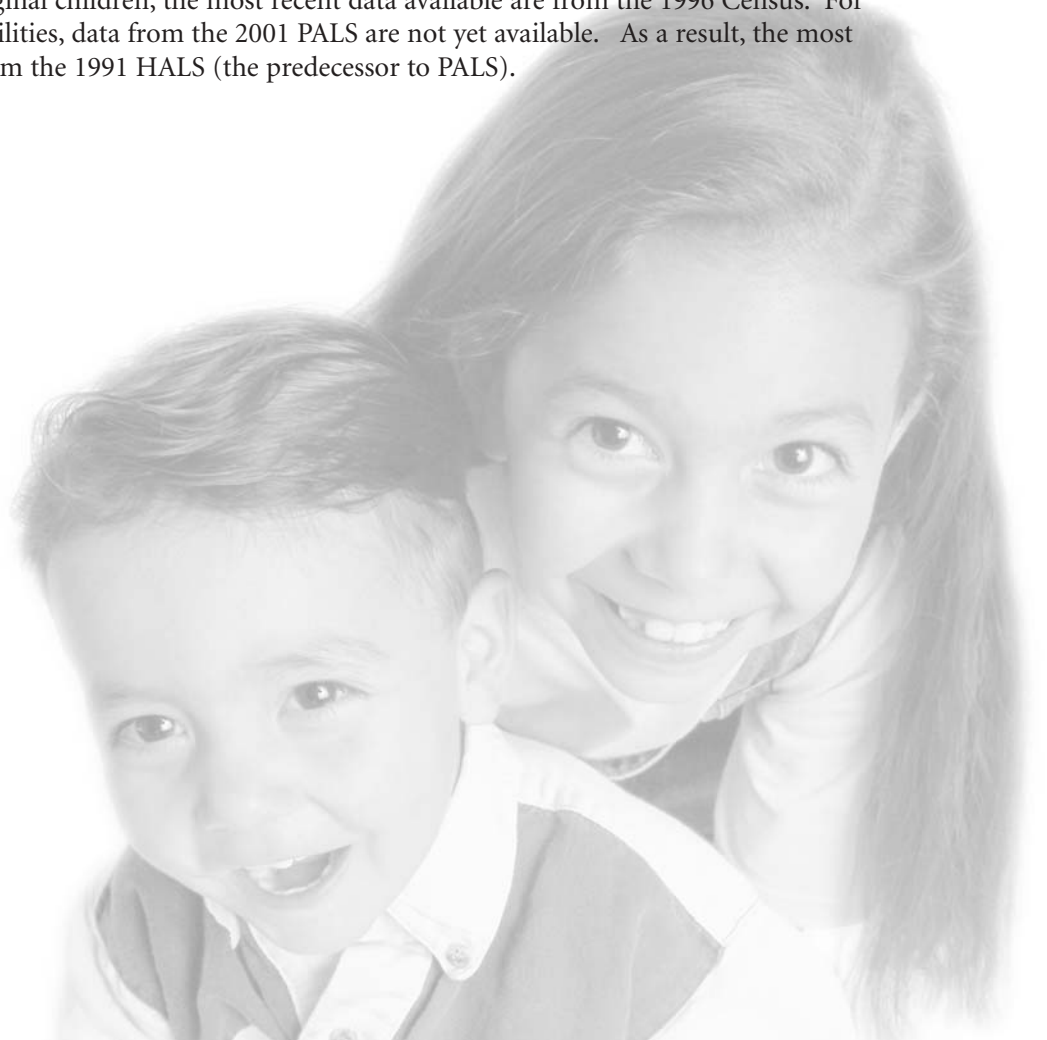
⁶ Initial release of the APS is planned for late in 2003.

⁷ Additional information on these surveys is presented in Chapters 4 and 5 of this report.

More recently, implementation of the National Longitudinal Survey of Children and Youth (NLSCY) has helped to broaden knowledge about children in Canada, and in particular young children. The first collection cycle of the NLSCY (collected in late 1994 and early 1995) interviewed parents of about 23,000 children up to the age of 11. They shared information not only about their children, but also about themselves and the children's families, schools and neighbourhoods. Data were collected from the same families and children in subsequent cycles conducted in 1996-1997, 1998-1999, 2000-2001 and 2002-2003 and will be collected every two years until the children reach adulthood. For each of these cycles, children from birth to 5 years of age are being added to the original sample to help further our understanding of learning and development in the early years of life.

The NLSCY is the primary data source for many of the indicators of child well-being presented in this report. The most recent data available for the NLSCY are from Cycle 3 (1998-1999). Consequently, the data presented in this report are focused on Canadian children who were 5 years of age or younger in the years 1998 and 1999. This will help establish a baseline against which future changes in child well-being can be measured.

There are a few noted exceptions where the data presented are for a different reporting year. For example, for Aboriginal children, the most recent data available are from the 1996 Census. For children with disabilities, data from the 2001 PALS are not yet available. As a result, the most current data are from the 1991 HALS (the predecessor to PALS).



Chapter 2: A PORTRAIT OF CANADA'S YOUNG CHILDREN



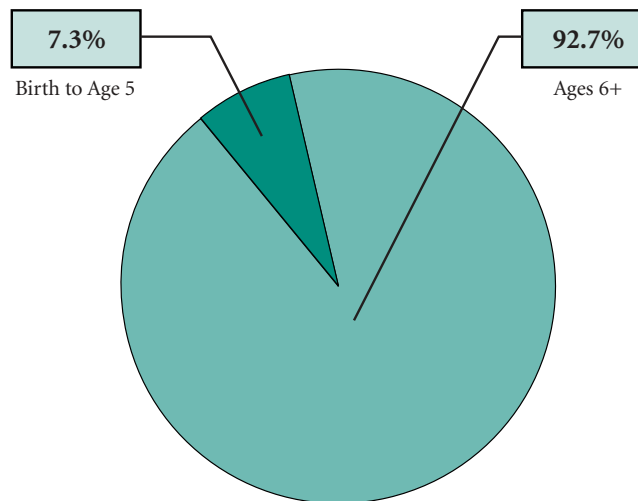
An Overview of Canada's Young Children

Young children in Canada all have unique lives. Understanding who these children are will help us to support each of them to reach their own unique potential – to be healthy, safe and secure, to be eager and able to learn, and to participate in their communities.

7.3% of the Canadian population were between birth and 5 years of age in 1999

On July 1, 1999 there were 2,224,935 children from birth to age 5 in Canada, representing 7.3% of the total Canadian population. These children are relatively equally distributed among the individual ages.

Figure 1: Proportion of children from Birth to Age 5, Canada, July 1, 1999

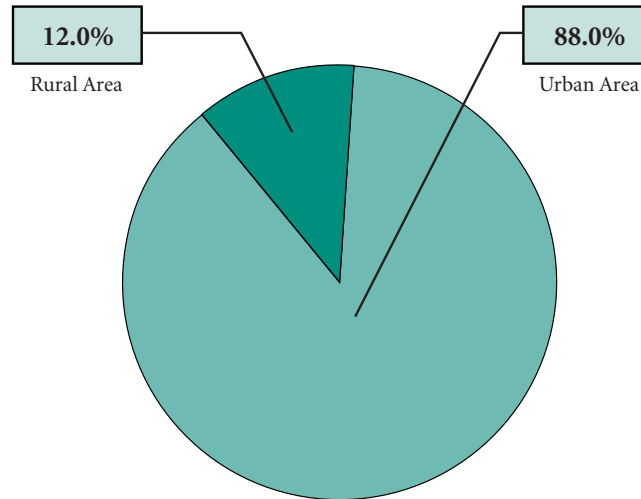


Source: Annual Population Estimates, Demography Division, Statistics Canada

Of these children, 51.2% were boys (1,139,595 children) and 48.8% were girls (1,085,340 children).

The majority of young children live in an urban setting

Figure 2: Distribution of Children by Place of Residence, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

Canada continues to be a predominantly urban country. In 1996, 77.9% of the total Canadian population lived in an urban area.⁸ This pattern is even more pronounced for young children. In 1998-1999, 88% of all children from birth to age 5 lived in urban areas⁹ (1,904,070 children).

⁸ Statistics Canada, *Urban and Rural Population Counts for Provinces and Territories, 1996 Census - 100% Data*. Catalogue No. 93-357-XPB.

⁹ The NLSCY uses the Statistics Canada Census classification for urban and rural areas. According to the 2001 Census Dictionary (Catalogue No. 92-378-XIE), an urban area is an area with a population of at least 1,000 people and a minimum of 400 people per square kilometre. A rural area includes all living in territory outside urban areas.

How Healthy Are Our Young Children?

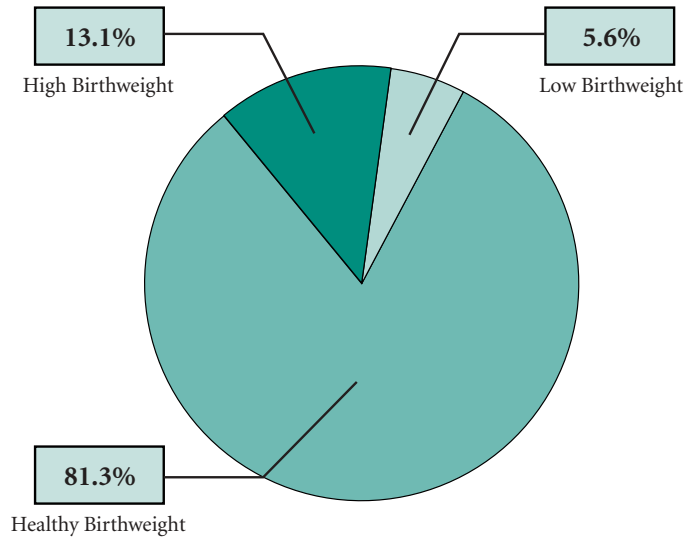
Research has shown that the health of children during their first years has an impact on how they function later on in life.

The following section presents key information on the health of young children in Canada.

Over 80% of children are born at a healthy weight

A child's weight at birth is a key indicator of development both in utero and after birth. Children born at a low birthweight face a number of potential problems, including increased risk of dying during the first year of life, developmental disabilities and disease.¹⁰ Children born at a high birthweight are at greater risk of death within the first month of life, injuries during birth, and intellectual and developmental problems.¹¹

Figure 3: Distribution of Young Children by Birthweight, Canada, 1999



Source: Canadian Vital Statistics - Birth Database

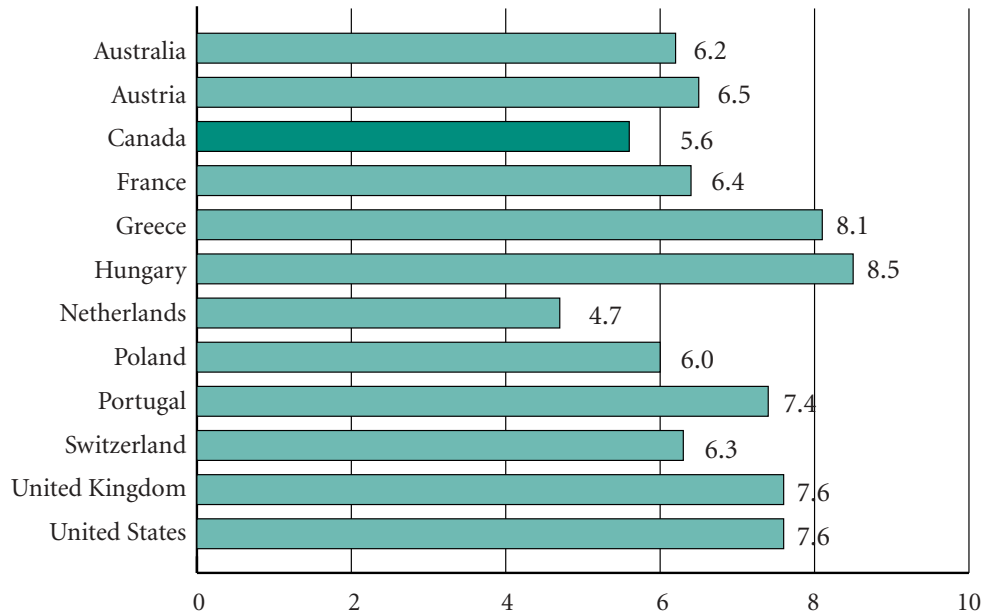
¹⁰ Government of Canada (2002) *Healthy Canadians - A Federal Report on Comparable Health Indicators 2002*. Ottawa: Health Canada.

¹¹ MacMillan, H. et al. "Chapter 1 - Children's Health". *First Nations and Inuit Regional Health Survey*. Ottawa.

A healthy birthweight is defined as between 2500 and 4000 grams. Children weighing less than 2500 grams are considered to be of low birthweight and children weighing more than 4000 grams are considered to be of high birthweight. In 1999, **81.3%** of all Canadian children (or 273,845 children) were born at a healthy weight.

More females than males are born at a healthy birthweight; 84% compared to 79%. Girls are more likely to be born at a low birthweight (under 2500 grams) while boys are more likely to be born at a high birthweight (over 4000 grams). Typically, over half of low birthweight children are premature.¹²

Figure 4: Percentage of Children Born at a Low Birthweight, Selected OECD Countries, 1999



Source: Organisation for Economic Co-Operation and Development, *OECD Health Data 2002*

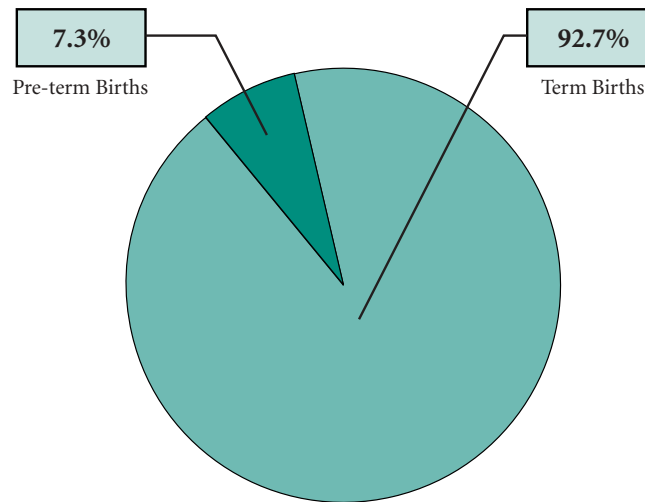
Compared to other member countries of the Organisation for Economic Co-Operation and Development (OECD), Canada had one of the lowest percentages of children born at a low birthweight, at 5.6% in 1999.

¹² Federal, Provincial and Territorial Advisory Committee on Population Health (1999) *Statistical Report on the Health of Canadians*. Ottawa: Government of Canada.

Few Canadian children are born premature

The traditionally accepted gestation period for a child is a minimum of 37 weeks. A child born before that time is considered to be “pre-term.” Being born early can have an impact on child development as these children are typically more susceptible to low birthweights and associated health problems.

Figure 5: Pre-term Birth Rate, Canada, 1999



Source: Canadian Vital Statistics - Birth Database

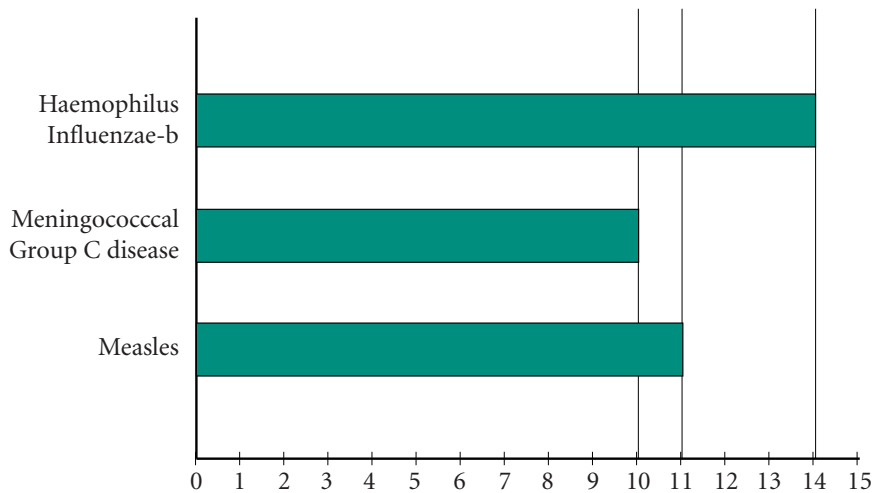
In 1999, **92.7%** of all children were born at 37 weeks of gestation or later (312,389 children). Pre-term births are more prevalent among males than females; 7.7% of all boys (13,281 children) were born early compared with 6.9% of all girls (11,268 children).

Canada continues to maintain the lowest incidence of measles and Haemophilus influenzae-b in its history

Childhood immunization is essential to protect against various disabling and even fatal diseases.¹³ Until recently (prior to immunization), infectious childhood diseases were a significant cause of illness, disability and death. With high levels of immunization, children in Canada are able to enjoy a high level of security from these serious diseases.¹⁴

While Canadian children are immunized against several diseases, up-to-date national vaccine coverage rates are not available. Work is under way to obtain reliable data on the number of children from birth to age 5 immunized for all vaccine preventable diseases in Canada. Until these data are available, the Government of Canada has chosen to report on the incidence of three vaccine preventable diseases which must be reported by doctors across Canada if they occur: Haemophilus influenzae-b (Hib), meningococcal group C disease and measles.

Figure 6: Number of Cases of Selected Vaccine Preventable Diseases, Canada, 1999



Source: Division of Immunization and Respiratory Diseases, Centre for Infectious Disease Prevention and Control, Health Canada.

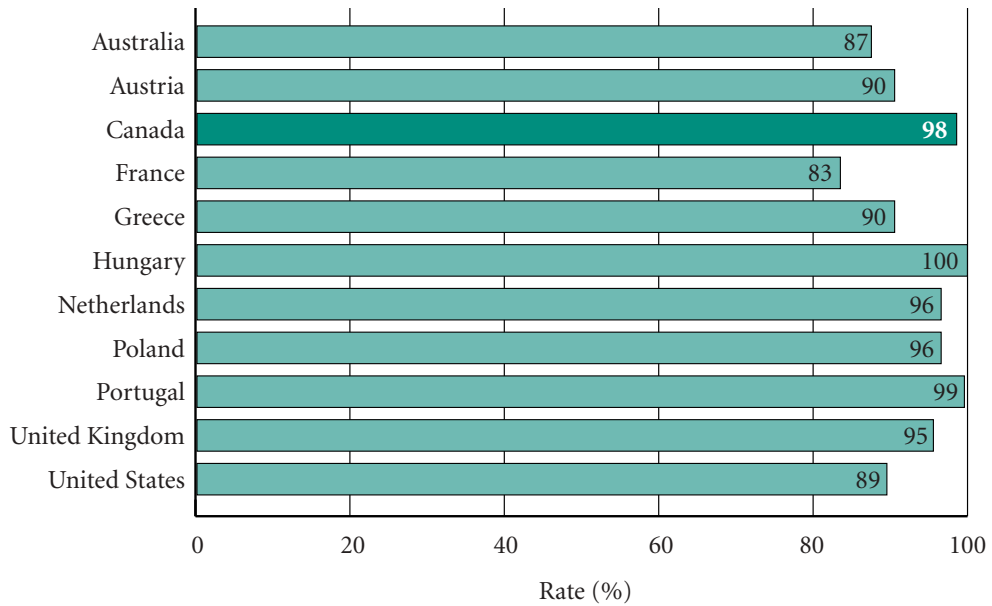
Note: For measles and meningococcal disease, cases include children from birth to 5 years; for Hib, cases include children from birth to 4 years.

¹³ Ibid.

¹⁴ Canadian Institute of Child Health (2000) *The Health of Canada's Children – Third Edition*. Ottawa: Canadian Institute of Child Health.

In 1999, there were **14** cases of Hib, **10** cases of group C meningococcal disease and **11** cases of measles documented in Canada. It is important to note that since 1998, all cases of measles have been imported or import-related.

Figure 7: Rate of Vaccination Coverage for Measles, Children Less Than 1 Year of Age, Selected OECD Countries, 1997



Source: The World Bank (1999) World Development Indicators 1999, Washington, D.C

Note: For Canada, the vaccine coverage rate is for children at 2 years of age.

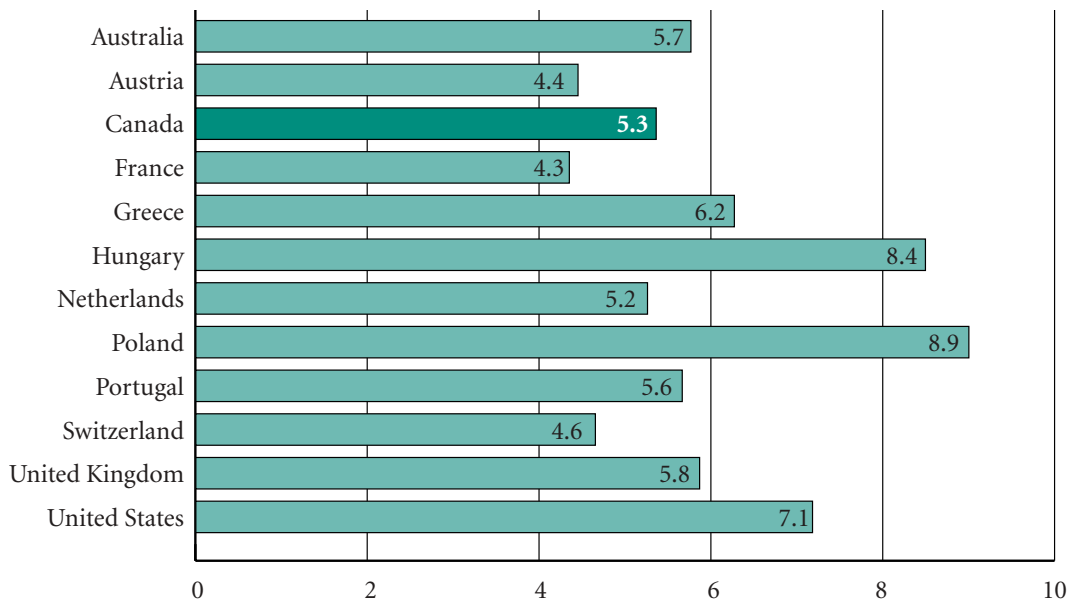
Internationally, in 1997, at 98%, Canada had one of the highest rates of vaccination coverage for measles among very young children. This high rate of vaccination coverage, a 2-dose catch-up campaign in 1996, and a routine 2-dose program implemented in 1996-1997, have helped Canada to maintain the lowest incidence of measles in the country's history.¹⁵

¹⁵ In 1995, the National Advisory Committee on Immunization (NACI) reaffirmed Canada's commitment to the goal of the elimination of measles by recommending a second dose of measles vaccine be administered routinely at least one month after the initial dose, to raise protection as high as possible. In addition, a special catch-up program of the second dose of measles vaccine was implemented by provincial and territorial ministries for those children and adolescents previously immunized with one dose.

Canada has a low infant mortality rate

Infant mortality refers to the rate of children who die within the first year of life but does not include still births. The infant mortality rate in Canada has declined over the past two decades.¹⁶ In Canada, the infant mortality rate for 1999 was **5.3 deaths per 1,000 live births**. This rate varied slightly for boys and girls; for boys it was 5.7 deaths per 1,000 live births while for girls it was 4.8 deaths per 1000 live births.

Figure 8: Infant Mortality Rate (per 1,000 Live Births), Selected OECD Countries, 1999



Source: Organisation for Economic Co-Operation and Development, *OECD Health Data 2002*

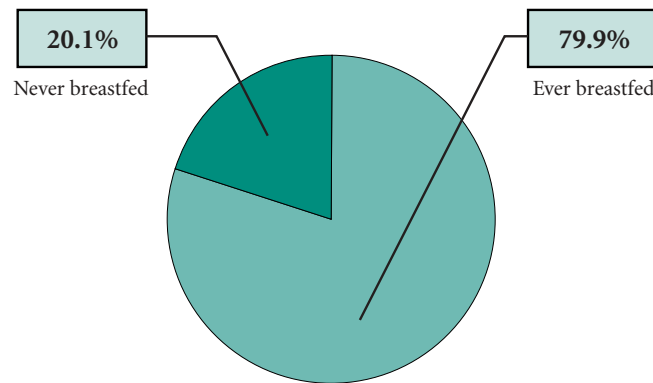
According to data from the OECD, the Canadian infant mortality rate is comparable to other developed countries.

¹⁶ Government of Canada (2002). *Healthy Canadians – A Federal Report on Comparable Health Indicators 2002*. Ottawa: Health Canada.

The majority of children in Canada were breastfed during infancy

A baby who is breastfed is not only receiving good nutrition but also experiencing the stimulation of touch, sight, sound, taste, warmth and smell, all of which help foster positive child development. In addition, experts agree that human breast milk contains the perfect balance of nutrients a baby needs to develop.¹⁷

Figure 9: Percentage of Children from Birth to 3 Years of Age Breastfed, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

Note: Includes both children currently being breastfed as well as children who were ever breastfed

In 1998-1999, **79.9%** of Canadian children from birth to age 3 (1,115,868 children) were either being breastfed or had been breastfed previously.

Experts agree that the optimal duration for breast feeding a baby is six months or more.¹⁸ Of those children who had been or were being breastfed, 32.5% had been breastfed for 12 weeks or less, 33.4% had been breastfed for 3 to 6 months and 34% had been breastfed for 7 months or longer.

Children living in urban areas are slightly more likely to have been breastfed than their counterparts living in rural regions. In 1998-1999, 80.8% of children up to and including 3 years of age living in urban areas had been or were being breastfed compared to 72.8% living in rural regions.

¹⁷ McCain, Hon. Margaret Norrie and Mustard, J. Fraser (1999) *Reversing the Real Brain Drain – Early Years Study Final Report*. Toronto: Children's Secretariat, Government of Ontario.

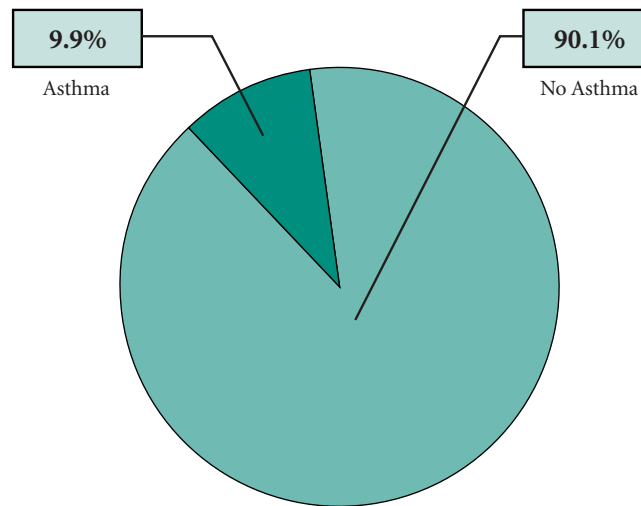
¹⁸ Canadian Institute of Child Health (2000) *The Health of Canada's Children – Third Edition*. Ottawa: Canadian Institute of Child Health.

Roughly 1 in 10 young children has asthma

Asthma, a chronic inflammatory disorder of the airways, is one of the most prevalent chronic conditions in Canada. It is not uncommon for children to be diagnosed with asthma during their preschool years.¹⁹ The existence of asthma can have an impact on child development. In severe cases, asthma may limit the activities in which a child can participate.

In 1998-1999, **9.9%** of young children (213, 648 children) had been professionally diagnosed with asthma. This represents an increase of 1.6% more children than were diagnosed in 1994-1995.

Figure 10: Prevalence of Diagnosed Asthma Among Young Children, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

Of those children who had been diagnosed with asthma, 12.3% (26,410 children) indicated that having asthma limited the activities in which they could participate.

In addition, the number of children with asthma was higher in urban than rural areas. In 1998-1999, 10.2% of children living in urban areas had professionally diagnosed asthma compared to 8.0% living in rural regions.

¹⁹ Ibid.

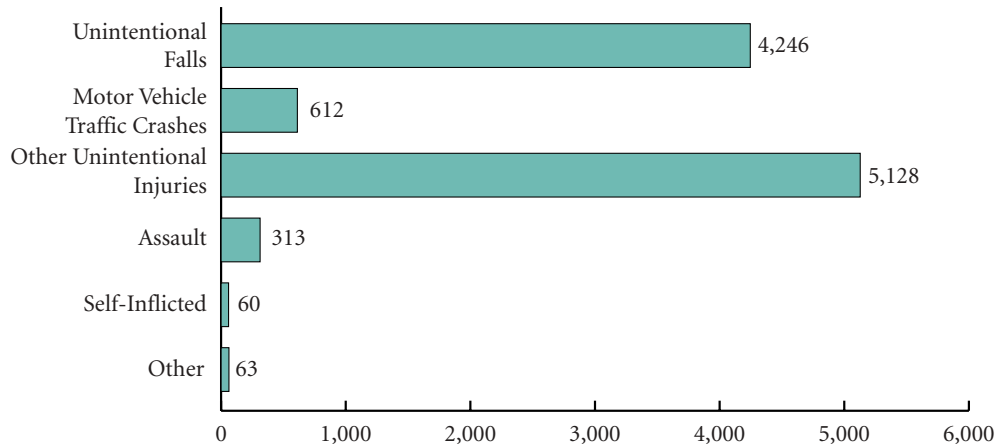
Are Young Children Safe and Secure?

It is important to ensure that our children grow up feeling safe and secure. “For optimal development, children need secure homes, violence-free family environments and protection from victimization.”²⁰

The following section provides some preliminary data on the safety and security of young children in Canada.

Young children in Canada are relatively safe from injury

Figure 11: Hospitalizations Resulting from Injuries, Children from Birth to 5 Years of Age, Canada, Fiscal Year 1999-2000



Source: Canadian Institute of Health Information, Hospital; Morbidity Database 1999.

In fiscal year 1999-2000, the majority of children hospitalized as the result of an injury had suffered a fall or an “other unintentional injury”. Examples of “other unintentional injuries” are accidental poisonings or cuts and burns. In general, boys were more likely than girls to receive treatment at a hospital for an injury.

Based on 1998-1999 data,²¹ approximately 60% of injuries for children from birth to 5 years of age presented at hospital emergency departments occurred in their own home. As children get older, the range of locations in which they sustain injuries broadens²² – associated with the fact that they are increasingly likely to participate in more activities outside the home.

²⁰ Federal/Provincial/Territorial Council of Ministers on Social Policy Renewal (1999) *A National Children's Agenda – Developing a Shared Vision*. Canada.

²¹ These data are derived from the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP), Canada's principal injury surveillance program. CHIRPP collects data from the emergency departments of 10 pediatric and 5 general hospitals across Canada.

²² Health Canada. The Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP), 1998-1999.

Injuries are a cause of death among children. Consequently, in recent years, there has been an increased focus on the prevention of childhood injuries. In 1999, **9.6%** of all deaths among young children were the result of an injury. However, injuries are a much more prominent cause of death among children ages 1 to 5 years (51%) than they are for children less than 1 year of age (2.1%). The primary causes of injury-related deaths for children between birth and 5 years of age include motor vehicle traffic crashes and assault.

Keeping Young Children Safe and Secure

One of the ways in which Canadians can ensure their young children are safe and secure is to protect them from maltreatment such as abuse and neglect.

In 1998, there were an estimated 48,790 child maltreatment investigations in Canada among children from birth to 5 years of age. Of these, approximately 20,476 (42%) were substantiated, 10,817 (22%) were suspected and 17,497 (36%) were unsubstantiated. Sixty-three percent of all sexual abuse investigations involved female children and 37% involved males. For other categories of child maltreatment, including physical abuse, neglect and emotional maltreatment, more than half of the investigations involved male children.²³

Work is currently under way on Cycle II of the Canadian Incidence Study of Reported Child Abuse and Neglect.



²³ Data provided by the Injury and Child Maltreatment Section, Division of Health Surveillance and Epidemiology, Health Canada.

How Are Young Canadian Children Developing?

It is important to know how children are developing emotionally and cognitively as well as physically. In many instances, the onset of emotional and behavioural problems in childhood can lead to a lifetime of related problems.²⁴ The NLSCY is a valuable tool to capture information on children's emotions and behaviours as it incorporates measures of prosocial behaviour, hyperactivity-inattention, emotional problems-anxiety and aggression. The NLSCY also evaluates a child's motor and social development as well as language abilities.

Measuring Motor and Social Development in the National Longitudinal Survey of Children and Youth

The NLSCY incorporates a scale consisting of a set of 15 questions that measure dimensions of the motor and social development of young children from birth through 3 years. Within this scale, the questions used to capture motor and social development are age sensitive. These questions are answered by the person most knowledgeable about the child and reflect a parental assessment of the child's motor and social development, not a professional diagnosis.

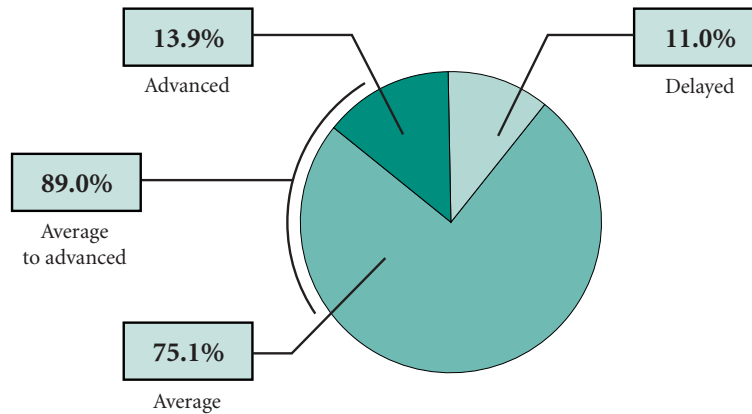
The results of these questions are combined into a standardized scale in which the average score for the population is set at 100 with a standard deviation of 15. This standardized score takes account of the child's age and allows for comparisons of scores to be made across age groups. Based on the score, children scoring between 85 and 115 were considered to have average development. Children scoring below 85 displayed symptoms of delayed development while those scoring above 115 points displayed advanced development.



²⁴ Offord, David R. and Lipman, Ellen L. (1996) "Emotional and Behavioural Problems" in *Growing Up in Canada – National Longitudinal Survey of Children and Youth*. Ottawa: Human Resources Development Canada and Statistics Canada.

89% of children display no delays in motor and social development

Figure 12: Distribution of Children from Birth to 3 years of Age by Score on the Motor and Social Development Scale, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

In 1998-1999, **89%** of children from birth to 3 years of age (1,201,059 children) displayed average to advanced levels of motor and social development.

Children who had lower levels of motor and social development were more likely to have difficulty doing such activities as crawling/walking unassisted and/or riding a tricycle in comparison to other children their age. In addition, these children were less likely to be able to clearly communicate wants/desires. Of the 11% of children who showed signs of delayed motor and social development, there were more girls than boys.

The Measurement of Behaviour in the National Longitudinal Survey of Children and Youth

This report discusses four measures of behaviour from the NLSCY: emotional problem-anxiety, hyperactivity, physical aggression-conduct problem and prosocial behaviour. For each behaviour, a set of questions is used and the answers combined into a scale to give a more valid representation of the different types of behaviour. These questions are answered by the person most knowledgeable about the child, reflecting a parental assessment of the child's behaviours, not a professional diagnosis.

Examples of the types of behaviours captured for each measure follow:

Emotional Problem-Anxiety is characterized by feelings of anxiety/nervousness or depression (i.e. child cries a lot, is sad or unhappy).

Hyperactivity is characterized by restlessness, fidgeting, lack of concentration and inability to wait for his or her turn.

Physical Aggression-Conduct Problem is identified if the child gets into fights, is threatening or physically aggressive.

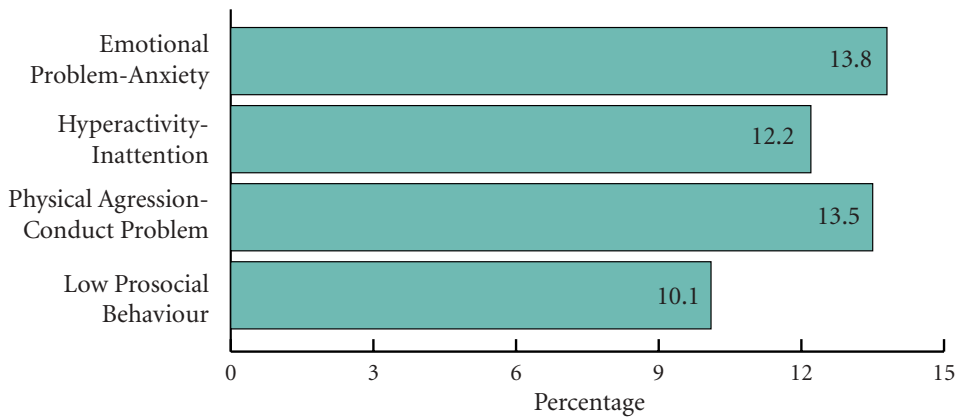
Prosocial Behaviour is identified if the child is sympathetic and/or volunteers to help others.

To identify the presence of behavioural problems, thresholds (or cut-off points) were identified for each of the behaviours. These thresholds were established by taking the scale score that is closest to the 90th percentile for each of the individual scales. The data presented represent the proportion of children who exhibit signs of problems for each of the individual behaviours.



The majority of children do not exhibit signs of behaviour problems

Figure 13: Percentage of Young Children Showing Signs of Behavioural Problems, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

Children with emotional problems/anxiety are more likely to appear unhappy, depressed or nervous than other children. In 1998-1999, **86.2%** of children between the ages of 2 and 5 years did not display signs associated with emotional problems-anxiety.

Children who appear restless and/or hyperactive and have a tendency to fidget or lose concentration quickly are exhibiting signs associated with hyperactivity-inattention. In 1998-1999, **87.8%** of children between the ages of 2 and 5 years did not display signs associated with hyperactivity-inattention.

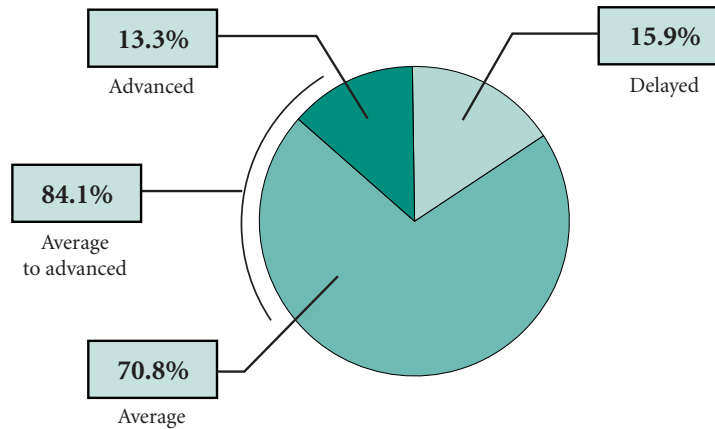
Children who tend to get into fights, are physically aggressive (i.e. kicking, biting) and/or destroy belongings are demonstrating signs associated with physical aggression-conduct problems. In 1998-1999, **86.5%** of children between the ages of 2 and 5 years did not display signs associated with physical aggression-conduct problems.

Of those children who displayed behavioural problems, boys consistently displayed higher levels of emotional problems-anxiety, hyperactivity-inattention and physical aggression-conduct problems than girls. The greatest difference was in the area of physical aggression-conduct problems with 16.6% of boys displaying high levels of this behaviour compared to 10.2% of girls.

The display of prosocial behaviour is also used as a measure of a child's behaviour. A child who is helpful, comforting and/or shows sympathy to others is exhibiting signs of prosocial behaviour. In 1998-1999, **89.9%** of all children ages 2 to 5 displayed average to high levels of prosocial behaviour. Girls were more likely than boys to display average to high levels of prosocial behaviour (91.8% of girls versus 87.8% of boys).

The majority of children exhibit an ability to hear/understand vocabulary

Figure 14: Distribution of 4- and 5-Year-Old Children by Score on the PPVT-R, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

In 1998-1999, over **84.1%** of all 4- and 5-year olds displayed average to advanced levels of verbal development (83,123 children). Of those, 13.3% displayed advanced levels of verbal development. Children with advanced verbal development are more likely to be able to do such activities as word association (matching words to the appropriate picture), which is a strong predictor of a child's future abilities to read and learn.

In 1998-1999, boys were more likely than girls to display delayed verbal development (16.5% versus 15.3% respectively) but were also more likely to display advanced verbal development (14.1% versus 12.5%).

Measuring Language and Receptive Vocabulary in the National Longitudinal Survey of Children and Youth

The Peabody Picture and Vocabulary Test – Revised (PPVT-R) is a direct assessment tool intended to measure receptive or hearing vocabulary in children ages 4 and 5 years. The interviewer administers the test directly to the child in either English or French once the child's parents have given consent.

Based on the results of the test, a standardized score is developed, in which the average score for the population is set at 100 with a standard deviation of 15. This standardized score takes account of the child's age and allows for comparisons of scores to be made across age groups. Based on the standardized score, a child who scored between 85 and 115 displays average verbal development. A child who scores 84 or below displays delayed verbal development while a child with a score of 116 plus displays advanced verbal development.

Highlights

In Canada, in 1998-1999, young children from birth to 5 years of age were developing well:

- 81.3% of babies were born at a healthy birthweight.
- 92.7% of children were born full term.
- Canada continued to maintain the lowest incidence of measles and Haemophilus Influenzae-b in its history.
- The infant mortality rate in Canada was 5.3 children per 1,000 live births.
- 79.9% of children from birth to 3 years of age were either being breastfed or had been breastfed previously.
- 1 in 10 young children had been professionally diagnosed with asthma.
- The majority of injuries to young children for which they were treated at hospital were caused by accidental falls, cuts and burns.
- 9.6% of all deaths among young children were the result of an injury.
- 89% of children from birth to age 3 showed signs of average to advanced motor and social development.
- 86.2% of children between the ages of 2 and 5 years did not display signs associated with emotional problems-anxiety.
- 87.8% of children between the ages of 2 and 5 years did not display signs associated with hyperactivity-inattention.
- 86.5% of children between the ages of 2 and 5 years did not display signs associated with physical aggression-conduct problems.
- 89.9% of all children ages 2 to 5 displayed average to high levels of prosocial behaviour.
- 84.1% of children aged 4 to 5 years displayed average or advanced levels of verbal development.

Chapter 3: A PORTRAIT OF CANADIAN FAMILIES



“Parents and families play the primary role in children’s lives, and a nurturing, supportive family is the best foundation for good child development.”²⁵ Intuitively we have always known that families and, in particular, parenting practices and lifestyle, influence children’s lives, either directly or indirectly. The family environment in which young Canadian children are growing up has changed dramatically over the past decades. The traditional two-parent family of the 1950s is no longer the only significant model of family life. Young children are born into a variety of different family types – married couples, common-law couples, lone-parent families and blended families. And the family to which the child is born is not guaranteed to be the family in which the child will spend his or her entire childhood since family structure is in a constant state of flux. In addition, today, many young women complete their education and begin their careers before they have children. However, despite these changes and the pressures associated with balancing work and family, parents still understand the importance of the first five years of life and are spending more time with their young children than a decade ago.²⁶

The objective of this chapter is to paint a portrait of the family environment in which the young children of today are growing up. As research becomes available, future reports will be able to explore the influences that families have on children’s outcomes. “Understanding the impacts of environmental influences can help us make choices that build more supportive environments for children and enhance their development.”²⁷ Specifically, this chapter will answer some key questions about the families in which young Canadian children are growing up: What kind of families do young Canadian children live in? Who are the parents of young Canadian children? How do they parent?

²⁵ Federal/Provincial/Territorial Council of Ministers on Social Policy Renewal (1999) *A National Children’s Agenda – Developing a Shared Vision*. Canada.

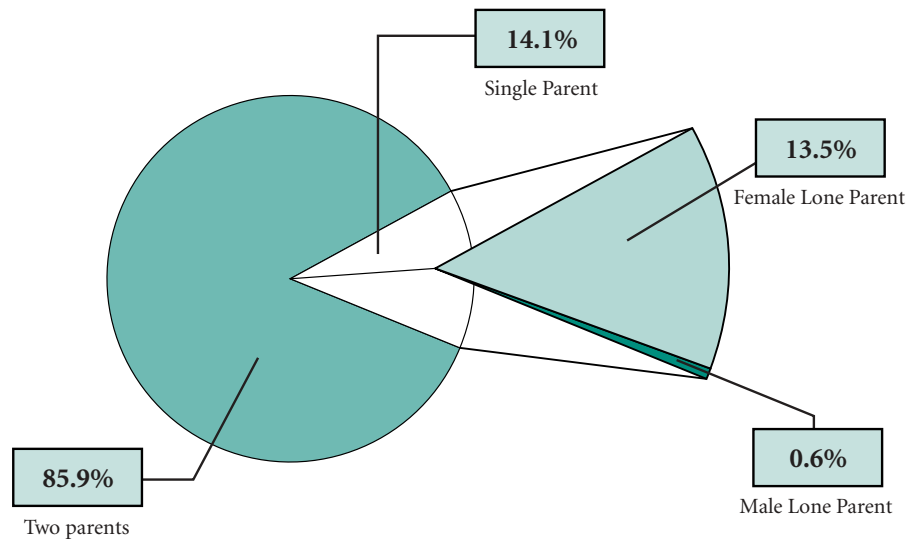
²⁶ Zuzanek, J. (Summer 2001) “Parenting Time: Enough or Too Little?” (pp. 125–133) in *Isuma – Canadian Journal of Policy Research*. Volume 2, Number 2.

²⁷ Federal/Provincial/Territorial Council of Ministers on Social Policy Renewal (1999) *A National Children’s Agenda – Developing a Shared Vision*. Canada.

What Kind of Families Do Young Canadian Children Live In?

The majority of young children are growing up in two-parent families – either blended or intact.²⁸ In 1998-1999, 86% of young children lived in two-parent families.

Figure 15: Distribution of Young Children in Canada by Family Type, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

The number of lone-parent families in Canada has increased in the past couple of decades. Between 1971 and 1991, the proportion of lone-parent families increased from 9.4% of all families to 13% of all families.²⁹ In 1998-1999, 14.1% of young children lived in lone-parent families. The proportion of female-led lone-parent families is substantially larger than male-led lone-parent families. In 1998-1999, 13.5% of all young children lived in a lone-parent family that was led by a female compared to 0.6% in male-led lone-parent families.

Children who experience parental separation do so at a younger age. Whereas approximately 5% of children born in the early 1960s experienced parental separation before their sixth birthday, almost 25% of children born in the late 1980s³⁰ would experience this phenomenon before their sixth birthday.

²⁸ A *blended family* is typically made up of one biological parent and one step-parent while an *intact family* consists of both biological parents.

²⁹ Péron, Y. "The Evolution of Census Families from 1971 to 1991" (pp. 47-100) in *Canadian Families at the Approach of the Year 2000*. Statistics Canada. Catalogue No. 96-321-MPE No.4.

³⁰ Marcil-Gratton, N. (1998) *Growing up with Mom and Dad? Children and Family Instability*. Ottawa: Human Resources Development Canada, Applied Research Branch.

The number and proportion of large families has declined over the past years. In 1901, the average family consisted of 4.5 people. By 1986, the average size had dropped to 3.1 people³¹ and further declined to 3.0 in 1998-1999. In 1998-1999, over 25% of young children in Canada were only children (did not have siblings).

In addition, mothers are choosing to have children later in life. With an increased focus on education and beginning a career, women are choosing to delay child birth. Consequently, since the 1960s, the average age of a mother at the birth of her first child has been steadily increasing. In the late 1960s, women were having their first baby around the age of 23. By 1999, this had increased to approximately 27 years of age.³²

With the increased age of the mother at child birth and decreased family size, the total fertility rate in Canada is declining. In 1999, the total fertility rate for Canada was 1.52 children per woman, representing, over the past 20 years, a 40% decline in the total fertility rate for women ages 20 to 24 and a 25% decline for women ages 25 to 29.

What type of housing and communities do these families live in?

The type of housing people live in tends to have an impact on their lifestyle.

Research conducted using 1996 Census data indicates that the majority of Canadian children from birth to 18 years of age live in households that meet the standards of affordability, suitability and adequacy, although 15% of children live in “core housing need,” where the housing does not meet one of these standards. Typically, children living in rental accommodations were much more likely to be living in core housing need (36% of rental households compared to 7% of owner households).³³

Parents wish to raise their children in neighbourhoods that are cohesive and foster a sense of safety and security. In 1998-1999, 84.9% of NLSCY respondents indicated that they felt a sense of satisfaction, safety and cohesion with the neighbourhood in which they lived.³⁴ In general, people living in rural communities were slightly more content with their neighbourhoods than those living in urban areas.

Beginning in the late 1990s, the Government of Canada began research in 13 selected Canadian communities to learn more about the influence of community factors on children's early development and to improve the community's capacity to use these data in monitoring child development and creating effective community-based responses. This initiative, called Understanding the Early Years (UEY) provides new information on the relationship between communities and child development. Future reports may present findings from the UEY initiative.

³¹ The Vanier Institute of the Family (2000) *Profiling Canada's Families II*. Ottawa: Vanier Institute of the Family.

³² Health Statistics Division, Statistics Canada.

³³ Canada Mortgage and Housing Corporation. *Research Highlights – Special Studies on 1996 Census Data: Housing Canada's Children*. (Socio-Economic Series, Issue 55-4). Ottawa: Government of Canada.

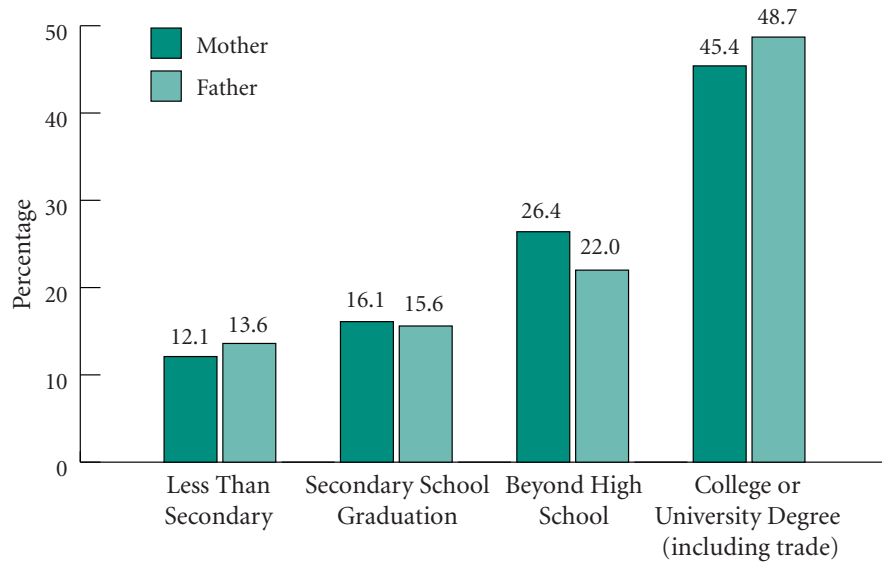
³⁴ The Neighbourhood Cohesion Scale in the NLSCY is used to measure the extent to which the person most knowledgeable about the child feels that there is cohesion within the community in which they live.

Who Are the Parents of Young Canadian Children?

Education

In the current knowledge-based economy, a high value is placed on education. “It is in skills and learning that our economic and social goals find common expression.”³⁵

Figure 16: Highest Level of Education of Parents of Young Children, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

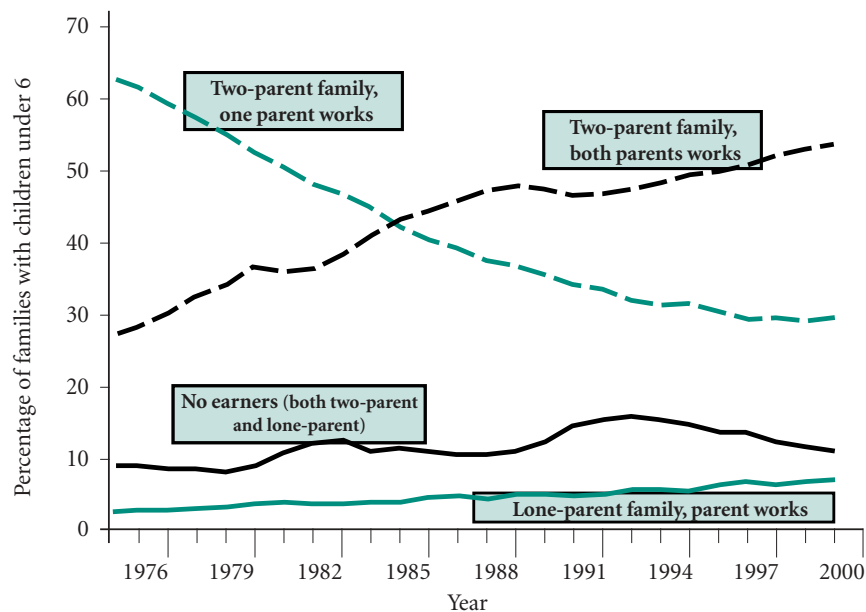
In 1998-1999, almost half of the parents of young children had obtained postsecondary education. As illustrated in figure 16, there was only a 3.3% difference in the proportion of fathers and mothers who had completed postsecondary education (48.7% of fathers compared with 45.4% of mothers). The number of mothers with young children who have a university or college degree has been steadily increasing over the past decade.

³⁵ Human Resources Development Canada (2002) *Knowledge Matters – Skills and Learning for Canadians. Canada's Innovation Strategy*. Ottawa: Government of Canada.

Work Outside the Home

A significant majority of young children have two parents working outside the home. In addition, the proportion of lone-parent families where the parent works outside the home has continued to rise.

Figure 17: Trends in Dual-Earner and Single-Earner Families with Young Children, Canada, 1976-2001



Source: Labour Force Survey, Public-Use Micro-File

Note: Due to data collection problems, data for 2000 have been omitted.

Even though more parents are working, mothers of young children report working fewer hours of paid work on average than either their spouses or women with older children.³⁶ In addition, fewer mothers with children under 1 year of age are working compared to mothers with children ages 1 to 5 years.

When compared to the countries in the European Union, Canada has among the highest percentage of employed mothers with young children. In 1996, 60% of Canadian mothers with at least one child under the age of 6 years were employed,³⁷ compared to 42% in Italy, 40% in Luxembourg and 36% in Spain.³⁸

³⁶ Silver, C. (2000, summer) "Being There: The Time Dual-Earner Couples Spend with Their Children" in *Canadian Social Trends*. Ottawa: Statistics Canada.

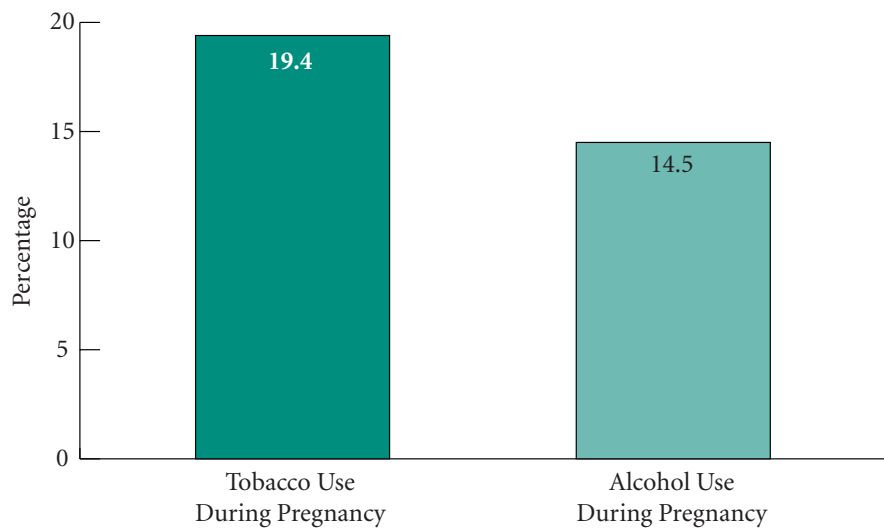
³⁷ Statistics Canada (1996) Canadian Census.

³⁸ Eurostat (1996) Custom Tabulation.

Health Risks

Over the past several years, an increased number of public awareness campaigns have advised on the dangers of smoking and drinking during pregnancy. Research indicates that smoking during pregnancy can lead to child health problems such as low birthweight and pre-term births. Alcohol consumption during pregnancy contributes to an increased risk of fetal alcohol syndrome/fetal alcohol effect.³⁹

Figure 18: Tobacco and Alcohol Use During Pregnancy, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

In 1998-1999, in Canada, 14.5% of mothers consumed some alcohol while pregnant and 19.4% of mothers smoked. In comparison, in the United States in 1999, approximately 13% of mothers smoked cigarettes while pregnant⁴⁰ while in the United Kingdom in 2000, 20% of mothers smoked during their pregnancy.⁴¹

³⁹ Fetal Alcohol Syndrome (FAS) is a medical diagnosis that refers to a specific cluster of anomalies associated with the use of alcohol during pregnancy. The three main characteristics of FAS are prenatal and/or postnatal growth restriction, characteristic facial features and central nervous system involvement.

Fetal Alcohol Effects (FAE) refers to children with prenatal exposure to alcohol, but only some FAS characteristics.

⁴⁰ *Health, United States, 2001, With Urban and Rural Health Chartbook*. (2001) United States: Department of Health and Human Services, Centers for Disease Control and Prevention and National Center for Health Statistics.

⁴¹ BMRB Social Research (2000) *2000 Infant Feeding Survey*. United Kingdom: Department of Health.

In addition to the warnings about substance use during pregnancy, society has become much more aware of the associated negative effects of second-hand smoke. Young children are particularly susceptible to the effects of environmental tobacco smoke (ETS), which can lead to a variety of health problems, both at birth as well as later on in life⁴² (such as low birthweight, asthma).

In 1998-1999, 72.6% of the persons most knowledgeable about the child (PMK) and 70.4% of their spouses did not smoke at all. Of those who did smoke, the majority did so daily. Research shows that the presence of a household member who smokes daily will greatly increase the likelihood that children in the same household are exposed to a polluted environment.⁴³

What are some of the challenges confronting the parents of young children?

Low Income

In Canada there is no official measure of poverty. Instead, there are several different measures that are used. The Low-Income Cut-Off (LICO) is one of the most widely used; it is a relative measure based on the percentage of income spent on basic needs by an average family. This measure can be examined using either pre-tax income or post-tax income.⁴⁴

Table 1: Percentage of Families with Young Children Living Below the Low-Income Cut-Off, by Family Type, 1999

	Two-Parent Family	Lone-Parent Family	All Families
Pre-Tax LICO (1992 base)	14.8	59.7	21.1
Post-Tax LICO (1992 base)	10.0	49.5	15.6

Source: Statistics Canada, Survey of Labour and Income Dynamics

In 1999, 21.1% of all families with children from birth to 5 years of age were living below the pre-tax LICO (and 15.6% were living below the post-tax LICO).

⁴² Federal, Provincial and Territorial Advisory Committee on Population Health (1999) *Statistical Report on the Health of Canadians*. Canada.

⁴³ Physicians for a Smoke-Free Canada (1999) *Highlight Sheet #1 – Smoking in Canadian Homes, Are Children at Risk?* Ottawa.

⁴⁴ The pre-tax LICO is set according to the proportion of annual pre-tax income (total income including government transfers before the deduction of income taxes) spent on basic needs (food, clothing and shelter). A household that spends 20% more on basic needs than the average family is considered to be living below the pre-tax LICO. The pre-tax LICO is adjusted for location and family size.

The post-tax LICO is set according to the proportion of annual post-tax income (total income including government transfers after the deduction of income taxes) spent on basic needs (food, clothing and shelter). Again, a household that spends 20% more on basic needs than the average family is considered to be living below the post-tax LICO. The post-tax LICO is also adjusted for location and family size.

Lone-parent families are more likely to live in low income than two-parent families. In 1999, 49.5% of lone-parent families were living below the post-tax LICO compared to 10% of two-parent families.

The depth of low income indicates the additional amount of income an average family with young children living below the LICO would need to reach the cut-off. In 1999, the average low-income family would have required an increase of either \$8,625 before tax or \$6,255 after tax to bring them to the LICO.

Parental Depression

Depression is a parental health characteristic which can potentially affect a “parent’s ability to play an effective role in the life of his or her child.”⁴⁵

The depression scale in the NLSCY represents a condensed version of the Depression Rating Scale (CES-D). This scale measures the occurrence and severity of symptoms associated with depression in the public at large, not the occurrence of clinically diagnosed depression. In the NLSCY, the scale captures the existence of symptoms of depression, as reported by the parent responding. Depression is measured by a poor appetite, an inability to shake off the blues and/or concentrate, feelings of depression and restless sleep.

In 1998-1999, 88.8% of respondents, who were typically mothers, indicated that they did not exhibit signs of depression.



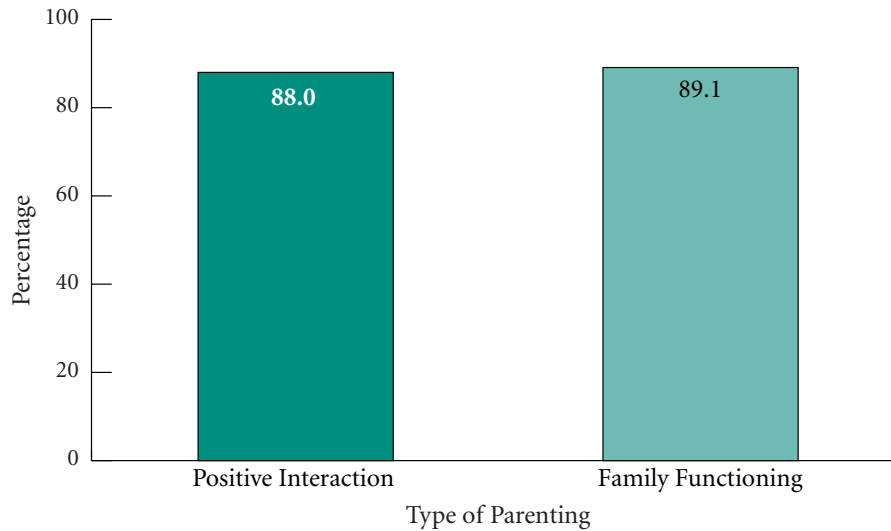
⁴⁵ Somers, M-A and Willms, J.D. (2002) “Maternal Depression and Childhood Vulnerability” (pp. 211–228) in J. Douglas Willms (ed.) *Vulnerable Children*. Edmonton: University of Alberta Press and Human Resources Development Canada.

What Do We Know About Parenting in Canada?

Parenting Style

Parenting style is one of the primary factors affecting children's outcomes. Two key measures of parenting style are positive interaction and family functioning.⁴⁶

Figure 19: Percentage of Parents of Young Children Displaying Positive Parenting Styles, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

In 1998-1999, 88% of parents indicated that they had positive interaction within the family. Parents who have a high level of positive interaction with their child(ren) tend to praise the child, play games with the child and laugh together.

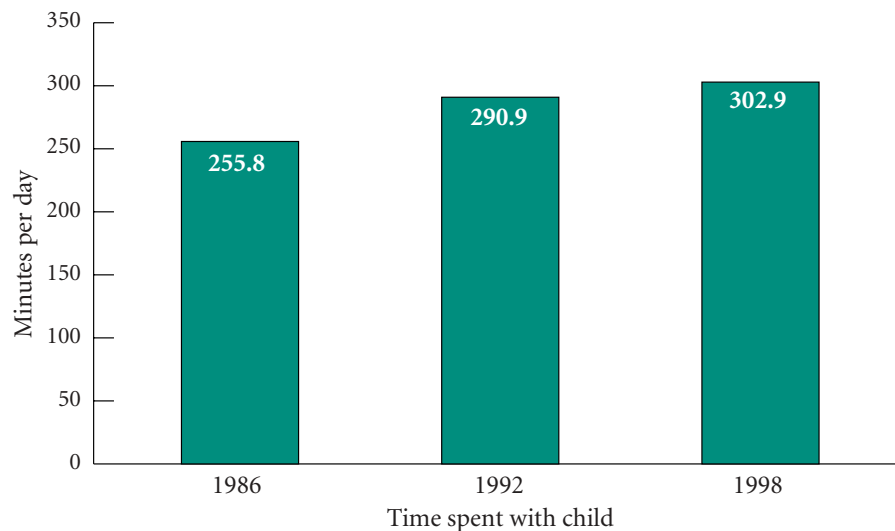
⁴⁶ The parenting scales in the NLSCY measure certain parental behaviours. The questions assessing parenting styles were administered to the PMK about the child or spouse/partner of the PMK. Positive interaction is one of the styles being measured. The family functioning scale provides a global assessment of family functioning (including problem solving, communication, roles, affective involvement, affective responsiveness and behaviour control) and indicates the quality of relationships between family members. This scale is administered to either the PMK about the child or the spouse/partner. The scale does not reflect a clinical diagnosis.

Family functioning refers “...to the way in which families work together on tasks that are necessary for the family unit to survive.”⁴⁷ A family that has a high level of functioning tends to participate in such activities as problem solving, communication and offering support to each other. In 1998-1999, 89.1% of families indicated positive functioning among family members.

Spending Time with Children

Canadian researchers have recently studied the time crunch being felt by parents as they try to balance work and family. The findings indicate that the amount of time parents working outside the home spend with their young children has been steadily increasing in recent years.⁴⁸ The research also suggests that the largest increase in time spent with children was seen in parents with at least one child less than 6 years of age. Despite the increase in time pressure arising from balancing work and family when both parents are working outside the home, parents are still finding time for their young children.⁴⁹

Figure 20: Time Spent with Children from Birth to 5 Years of Age by an Employed, Married Parent, Canada, 1986, 1992 and 1998



Source: Adapted from Jiri Zuzanek, “Parenting Time: Enough or Too Little?” in *Isuma – Canadian Journal of Policy Research*. Summer 2001, pp. 129. Data originate from the General Social Survey, Statistics Canada.

⁴⁷ Racine, Y. and Boyle, M.H. (2002) “Family Functioning and Children’s Behaviour Problems” (pp. 199–209) in J. Douglas Willms (ed.) *Vulnerable Children*. Edmonton: University of Alberta Press and Human Resources Development Canada.

⁴⁸ Time spent with children refers to the amount of time spent with the child by one or both parents and includes caring for the child.

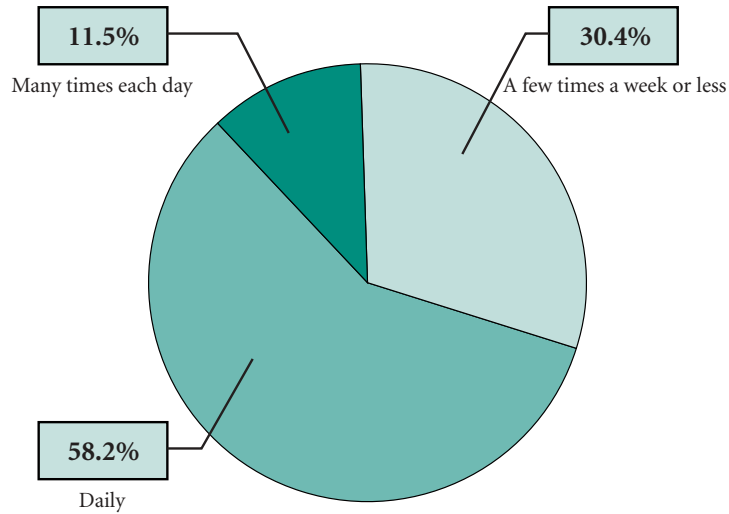
⁴⁹ Zuzanek, J. (Summer 2001). “Parenting Time: Enough or Too Little?” in *Isuma - Canadian Journal of Policy Research*. Volume 2 No. 2.

Many parents make use of non-parental child care arrangements when their children are young. In 1998-1999, 45.9% of parents who had children up to 5 years of age used care in a home setting by a non-relative as their primary child care arrangement. Another 31.5% of parents made use of care in a home setting by a relative (other than the parent) for those times when they could not be with their child(ren). The remaining 22.7% used services such as daycare centres, before and after school programs and nursery school.⁵⁰

Reading to a Child

For many children, the bedtime story is part of a nightly ritual. Reading exposes children to language and vocabulary as well as giving them contact with an adult. “Reading to a child has a particularly strong positive effect on both behaviour and preschool vocabulary skills.”⁵¹

Figure 21: Frequency That Young Canadian Children Are Read To, Canada, 1998-1999



Source: National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999)

In 1998-1999, almost 70% of all children from birth to 5 years of age were read to: at least once per day by the child’s parent or another adult (i.e. daycare worker, other relative).

⁵⁰ National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999).

⁵¹ Cook, C. and Willms, J.D. (2002) “Balancing Work and Family Life” in J.D. Willms (ed). *Vulnerable Children*. Edmonton: University of Alberta Press and Human Resources Development Canada.

Highlights

Parents play an important role in the lives of their children. The profile of the Canadian family presented reveals that:

- 85.9% of young children live in two-parent families.
- The number of lone-parent families increased from 9.4% to 13% between 1971 and 1991.
- Almost five times as many children experience parental separation before their sixth birthday as did their counterparts in the 1960s.
- Over 25% of young children are “only” children.
- Mothers are having children later in life.
- Most parents with young children feel a sense of satisfaction, safety and cohesion with the neighbourhood in which they live.
- Almost half of parents have postsecondary education.
- More mothers with young children are working outside the home.
- 19.4% of mothers smoked while pregnant and 14.5% consumed alcohol while pregnant.
- 84.4% of all families with young children are living above the post-tax low-income cut-off.
- 88.8% of parents do not report having signs of depression.
- Most young children benefit from positive parenting and family interaction.
- The amount of time parents working outside the home spend with their young children has been increasing.
- 69% of children are read to daily or several times per day.



Chapter 4: YOUNG ABORIGINAL CHILDREN IN CANADA – AN OVERVIEW⁵²



Aboriginal⁵³ children represent a precious resource through which Aboriginal communities and cultures can be sustained into the future. Yet relatively little is known about the health and development of young Aboriginal children in Canada. In particular, comprehensive national data concerning Aboriginal children are not readily available, especially for young children. For example, the National Longitudinal Survey of Children and Youth (NLSCY), which is the key source for much of the data presented in this report, does not include a representative sample of Aboriginal children. This chapter outlines what is known about the circumstances of young Aboriginal children using the most recent data available. It also identifies gaps in the understanding of the well-being of these children.

Potential Data Sources for Information on Young Aboriginal Children

The Census of Canada is the primary source of information for the Aboriginal population, providing basic demographic data such as age, gender, language knowledge and mobility. The census also provides information on the characteristics of the households and families within which Aboriginal children live.

The Aboriginal Peoples Survey (APS), conducted in 1991, provides limited information concerning Aboriginal children's use or knowledge of Aboriginal languages as well as their health status. A second APS was conducted in 2001. Those individuals reporting Aboriginal identity, Aboriginal ancestry, Registered or treaty Indian status or Band membership on the 2001 Census formed the basis for the sample. The Survey includes a children and youth questionnaire, which collects information on such issues as general health, health care utilization, social activities and relationships, and child care arrangements. It is hoped that this survey will yield some valuable information on the health and development of young Aboriginal children. Data will become available beginning late in 2003.

Health and developmental information was collected as part of the First Nations and Inuit Regional Health Survey, which was conducted on reserves across Canada in 1997. Although this survey provides some health and developmental indicators for children, it is not overly detailed and covers only part of the Aboriginal identity population (those living on reserve).

Data concerning registered Indians are also maintained by Indian and Northern Affairs Canada, covering topics such as age and gender, education, access to social services, and others. This information is mostly concerned with registered Indians living on reserve, and little information is available regarding young Aboriginal children.

⁵² Acknowledgement for the development of this chapter is extended to Jeremy Hull of Prologica Research.

⁵³ Using census data there are two broad ways of defining the Aboriginal population - those with Aboriginal ancestry and those with Aboriginal identity. In 1996, there were 1.1 million people in Canada with Aboriginal ancestry, compared to 800,000 identifying themselves as Aboriginal. In this chapter "Aboriginal" refers to the population defined by Aboriginal identity except where otherwise noted.

In addition, the census distinguishes among major social groups such as North American Indian, Métis and Inuit, and allows for the identification of specific ancestry groups such as Cree, Haida, Iroquois and many others.

While recognizing that the Aboriginal population is not a homogenous group, for the purposes of this chapter the data presented are generalized to the entire Aboriginal population, in particular to address the challenges associated with small sample sizes.

The Aboriginal population has a high proportion of young children

In 1996, there were 117,355 children between birth and age 5 for whom Aboriginal identity was reported. This represented about 15% of the total population with Aboriginal ancestry. Of these children, 32% (37,365) lived on reserve and 68% (79,990) lived off reserve. Of those living off reserve, 33,620 lived in rural areas, 15,965 lived in smaller cities (10,000 to 100,000 population) and 30,405 lived in large cities.

In the past, the Aboriginal population has grown rapidly, but this growth is expected to slow down during the period between 2001 and 2016. Between 1991 and 1996, the number of Aboriginal children from birth to 4 years of age grew by more than 10,000, or about 12%.⁵⁴ However, the Aboriginal population within this age group is expected to be smaller in 2016 than it was in 1991.⁵⁵ The birth rate among the Aboriginal population remains relatively high. For example, among the registered Indian⁵⁶ population, the birth rate was estimated at 28 per 1,000 in 1993 compared to 15 per 1,000 among the general population in 1993.⁵⁷

Young Aboriginal children often live in lone-parent families

In 1996, about 28% of Aboriginal children from birth to age 5 lived in lone-parent families. On reserves and in rural areas, the proportion of Aboriginal children living in lone-parent households was smaller, while in cities the proportion exceeded 40%.

Young Aboriginal children have a variety of living arrangements

In 1996, approximately 12% of Aboriginal children from birth to age 5 were not living with their parents. Most of these children were living with other relatives.⁵⁸

⁵⁴ Calculated from Statistics Canada, Age and Sex (Aboriginal Data 1991), Ottawa, 1993 and Statistics Canada Nation Series, 1996 Census, Table 25-003.

⁵⁵ Norris, M.J., Kerr, D. and Nault, F. (September 1996). *Royal Commission on Aboriginal Peoples, Projections of the Population with Aboriginal Identity, Canada, 1991–2016; Summary Report*. Ottawa: Canada Mortgage and Housing Corporation.

⁵⁶ The registered Indian population is made up of those who are eligible for registration under the *Indian Act*.

⁵⁷ Indian and Northern Affairs Canada (December 2001), *Aboriginal Women: A Profile from the 1996 Census*. Ottawa: Government of Canada.

⁵⁸ See Statistics Canada, *Nation Series*, 1996 Census, "Aboriginal Population in Private Households by Age and Sex, Showing Census Family Status for Canada, the Provinces, Territories and Census Metropolitan Areas, 1996 Census." (Table 25-003) This table shows that 9,875 of 12,615 children from birth to 4 years of age who were not in Census Families were living with relatives.

The majority of young Aboriginal children live in low-income families

In 1996, 58% of Aboriginal children from birth to age 5 were living in low-income families (based on the pre-tax low-income cut-off). The average income of Aboriginal lone-parent families is especially low. In 1995, Aboriginal female lone-parent families with children had an average annual income of about \$16,000. Seventy percent of Aboriginal lone mothers identified government transfer payments as their major source of income.⁵⁹

Young Aboriginal children experience high rates of mortality, injury and disability

In 1999, the infant mortality rate for First Nations populations was 1.5 times higher than that of other children in Canada.⁶⁰ In addition, the rate of deaths from injuries is 3 to 4 times higher for Aboriginal children than for other children in Canada.⁶¹ Persistent high levels of Sudden Infant Death Syndrome have also been documented among Aboriginal children.⁶²

The rate of severe disabilities among Aboriginal children living on reserves is much higher than for those living off reserve and more than twice as high as the rate for non-Aboriginal children.⁶³ Aboriginal children also have high rates of allergies, bronchitis and asthma.⁶⁴

More than half of registered Indian children living on reserves are breastfed

Based on the 1997 Regional First Nations and Inuit Health Survey, 54% of Aboriginal children less than 1 year of age had been or were being breastfed. More than half of these children were breastfed for more than 7 months.⁶⁵

⁵⁹ Hull, Jeremy (June 7, 2001) *Aboriginal Single Mothers in Canada, 1996*. Ottawa: Indian and Northern Affairs Canada, Research and Analysis Directorate.

⁶⁰ Government of Canada (2002) *Healthy Canadians – A Federal Report on Comparable Health Indicators 2002*. Ottawa: Health Canada.

⁶¹ Ibid.

⁶² Canadian Institute of Child Health. (2000). *The Health of Canada's Children - Third Edition*. Ottawa: Canadian Institute of Child Health.

⁶³ Ibid.

⁶⁴ MacMillan, H. et al. "Chapter 1 - Children's Health." *First Nations and Inuit Regional Health Survey: National Report*. Ottawa: Health Canada.

⁶⁵ Ibid.

Young Aboriginal children are affected by substance use

While there is a lack of comparable data on the use of alcohol and tobacco by mothers of young Aboriginal children compared to mothers of non-Aboriginal children, anecdotal evidence suggests that this is an issue for this group of children. In particular, use of alcohol by pregnant mothers is believed to pose a significant challenge in some Aboriginal communities. Based on scattered local and regional surveys, the incidence of fetal alcohol syndrome and effects (FAS/FAE) is believed to be much higher among Aboriginal children than among non-Aboriginal children, although no definitive statistics are available.⁶⁶

⁶⁶ Canadian Institute of Child Health (2000). *The Health of Canada's Children - Third Edition*. Ottawa: Canadian Institute of Child Health.

Highlights

This chapter provides a brief sketch of children from birth to 5 years of age with Aboriginal identity:

- The number of young Aboriginal children in Canada has been increasing but is expected to stabilize at its present level of about 120,000.
- 68% of young Aboriginal children live off reserve.
- 28% of young Aboriginal children live in lone-parent families.
- 12% of young Aboriginal children live with relatives other than their parents.
- 58% of young Aboriginal children live in low-income families.
- The infant mortality rate for the Aboriginal population is 1.5 times higher than the non-Aboriginal population.
- Aboriginal children experience high rates of some types of health problems, including injuries, disabilities and respiratory problems.
- Over 50% of young Aboriginal children had been previously or were being breastfed.





Chapter 5: YOUNG CHILDREN WITH DISABILITIES IN CANADA - AN OVERVIEW⁶⁷



Children with disabilities represent an important segment of the young Canadian population. An understanding of who these children are would help to ensure that they receive the support necessary to reach their potential. However, relatively little is known about the health and development of young children with disabilities. This can be partially attributed to the difficulties associated with defining "disability." The Health and Activity Limitation Survey (HALS) for Children (1991) identified children with disabilities based upon the presence of chronic conditions⁶⁸; use of technical aids (such as crutches, hearing aids or braces - excluding braces for teeth); long-term health problems that prevent or limit many activities considered typical for a child that age (such as participation in school, at play or in any other activity); enrolment in special education schools, in special classes or an individualized program; difficulty seeing, hearing or speaking; long-term emotional, psychological, nervous or mental health problems; or any other long-term health problem lasting six months or more.⁶⁹ This chapter outlines what is known about the circumstances of young children with disabilities using the most recent data available. It also identifies gaps in the information needed to provide a better understanding of these children.

Potential Data Sources for Information on Children with Disabilities

The 1991 Health and Activities Limitation Survey (HALS) is the primary source of information for children with disabilities. This survey provides basic demographic information such as age and gender as well as information on the nature and severity of the disability and barriers encountered in aspects of daily activities.

In 2001, HALS was replaced with the Participation and Activity Limitation Survey, which will provide information on disability type and severity for persons with disabilities, including young children. It will also provide information on a variety of areas including education, recreation and parents' labour force participation. Also important will be data on disability-related expenditures, how families fund such expenditures, and what supports and services are required (as well as the unmet need for supports and services). Data are expected to be released beginning in 2003.

The National Longitudinal Survey on Children and Youth (NLSCY), which is the key source for much of the data presented in this report, only provides limited information on children with disabilities as the sample size is small. Over time, the NLSCY might be particularly useful in helping understand more about detecting disability in children of various ages and the factors that are important in determining the outcomes for these children. The longitudinal nature of this survey can permit an examination of a variety of trajectories followed by children with disabilities. It can also be instrumental in future tracking of young children into adulthood to determine the link between some early chronic conditions and the development of activity limitations (and what variables might intervene in this process).

⁶⁷ Acknowledgement for the development of this chapter is extended to Kate Rexe, Gail Fawcett and Paul Roberts of the Canadian Council on Social Development.

⁶⁸ Chronic conditions include lung conditions or diseases other than allergies, asthma or bronchitis; heart disease or kidney conditions or diseases; cancer; diabetes; epilepsy; cerebral palsy; spina bifida; cystic fibrosis; muscular dystrophy; paralysis; arthritis or rheumatism; behavioural or emotional conditions; mental handicaps; learning disabilities; missing or malformed limbs; high blood pressure and others.

⁶⁹ Oderkirk, J. (Winter 1993) "Disabilities Among Children" in *Canadian Social Trends*. No. 31. Ottawa: Statistics Canada.

Young children have a low rate of disability

The rate of disability among young children in Canada is lower than it is among adults. This is partly because some disabilities in children have not yet been detected and also because the majority of disabilities are acquired after childhood. In 1986, 3.4% of Canadian children from birth to 4 years of age had a disability; by 1991, however, this had risen to 4.5% (5% for boys and 4% for girls)⁷⁰ representing 85,070 children.^{71,72} The reasons behind this increase are not well understood. It might be a result, in part, of a true increase in the incidence of certain types of disabilities or chronic illnesses; however, it might also be a result of earlier diagnosis and recognition of certain problems.

Most disabilities in young children are mild

The vast majority of disabilities among children are considered "mild" in nature.⁷³ According to the 1991 HALS, 89% of all children from birth to 4 years of age with disabilities had a mild disability (representing 75,710 preschoolers with disabilities).⁷⁴ It is estimated that less than 1% of all children with disabilities live in institutions.⁷⁵

Among very young children, chronic conditions are the most prevalent type of disability. In 1986, 90.6% of children from birth to 4 years of age with a disability had some form of chronic health problem, as opposed to a disability based primarily on activity limitation; the single largest group was those affected by heart disease - 15.4% of young children with disabilities.⁷⁶

One in five young children with disabilities lives in a lone-parent family

A fairly high proportion of children with disabilities live in lone-parent families; among children from birth to 5 years of age with an activity limitation, 20.5% lived in lone-parent families in 1994.⁷⁷

⁷⁰ Ibid.

⁷¹ Canadian Institute of Child Health (1994) *The Health of Canada's Children: A CICH Profile - 2nd Edition*. Ottawa: Canadian Institute of Child Health.

⁷² Census data from 1986, 1991 and 1996 for all Canadian children under 15 indicate a slow, but steady, increase in the disability rate over time for this population.

⁷³ Severity of disability in children is based upon the number of limitations or chronic conditions reported. When only one or two limitations or chronic conditions are reported, the disability is considered mild.

⁷⁴ Oderkirk, J. (Winter 1993) "Disabilities Among Children" in *Canadian Social Trends*. No. 31. Ottawa: Statistics Canada.

⁷⁵ Ibid.

⁷⁶ Avar, D. (1994) *Children and Youth with Disabilities in Canada: The 1986 Health and Activity Limitation Survey*. Ottawa: Canadian Institute of Child Health.

⁷⁷ NLSCY (1994) (Public-use Microdata file).

Less than half of pre-schoolers with disabilities in two-parent families have both parents in the paid labour force

Among young children with disabilities in two-parent families, 47.2% had both parents in the labour force,⁷⁸ a significantly lower percentage than for children without disabilities.

Almost one quarter of children with disabilities live in low-income families

Data from the NLSCY (1998-1999) indicate that 24.8% of children from birth to 5 years of age with special needs (including children with chronic conditions and/or activity limitations) lived in families with incomes below the low-income cut-off (using pre-tax LICO).⁷⁹

Balancing work, family and child care can lead to high levels of parental stress among parents of children with disabilities

Children with disabilities may rely on parents to take on multiple roles of therapist, teacher, playmate and advocate, in addition to providing physical care.⁸⁰ Survey research suggests that 93% of families with children with special needs⁸¹ reported feeling moderate to high levels of tension as a result of balancing work, family and child care responsibilities.⁸²

⁷⁸ NLSCY (1996) (Public-use Microdata file).

⁷⁹ National Longitudinal Survey of Children and Youth, Cycle 3 (1998-1999).

⁸⁰ *Voices for Children Home Page, 2002*. <http://www.voicesforchildren.ca> (September 6, 2002).

⁸¹ *Special needs* refers to "disabilities, delays or health disorders that significantly increase the difficulty of obtaining and keeping adequate child care and/or child care-related services." (According to S. Irwin and D. Lero in their book *In Our Way: Child Care Barriers to Full Workforce Participation Experienced by Parents of Children with Special Needs - and Potential Remedies*. pp. vi.)

⁸² Canadian Institute of Child Health (2000) *The Health of Canada's Children: A CICH Profile - Third Edition*. Ottawa: Canadian Institute of Child Health.

Highlights

This chapter provides a brief sketch of young children with disabilities living in Canada:

- In 1991, there were some 85,070 children from birth to age 4 with a disability in Canada, representing 4.5% of young Canadian children.
- 9 in 10 young children with disabilities had a "mild" disability.
- Among young children with disabilities, heart disease is the most prevalent underlying condition (15.4% of young children with disabilities).
- In 1994, 20.5% of young children with disabilities lived in lone-parent families.
- Less than half of young children with disabilities had both parents in the labour force.
- In 1998, 24.8% of young children with disabilities lived in families with incomes below the low-income cut-off (using pre-tax LICO).



Chapter 6: SUMMARY OF DATA PRESENTED

The following table provides a summary of the indicators of well-being for young children from birth to age 5 as well as the family- and community-related measures presented in this report. Those indicators denoted with an asterisk (*) are part of the common set of indicators of young children's well-being that all governments participating in the Early Childhood Development Agreement have agreed to report on.

Indicators of Child Well-Being	
Name	Indicator (1998-1999 unless otherwise indicated)
Healthy Birthweight*	81.3% of young children (1999)
Pre-term Birth Rate	92.7% of children born at 37 weeks of gestation or later (1999)
Incidence of Haemophilus Influenzae-b*	14 cases among young children (1999)
Incidence of Meningococcal Group C Disease*	10 cases among young children (1999)
Incidence of Measles*	11 cases among young children (1999)
Infant Mortality Rate*	5.3 deaths per 1,000 live births (1999)
Breastfeeding	79.9% of children were breastfed
Prevalence of Diagnosed Asthma	9.9% of young children diagnosed
Injury Hospitalization: (1999)	
Falls	4,246 cases
Motor Vehicle Traffic Crashes	612 cases
Other-Unintentional	5,128 cases
Assault	313 cases
Self-Inflicted	60 cases
Other	63 cases
Injury Mortality Rate	9.6% of all deaths among young children were the result of an injury (1999)
Motor and Social Development (MSD)*	89% of children displayed average to advanced levels
Emotional Problem-Anxiety*	86.2% of children did not display associated behaviours
Hyperactivity-Inattention*	87.8% of children did not display associated behaviours
Physical Aggression-Conduct Problem*	86.5% of children did not display associated behaviours
Low Prosocial Behaviour*	89.9% of children did not display associated behaviours
Language Skills*	84.1% of children displayed average to advanced verbal development

Family - and Community - Related Measures

Name	Measure (1998/1999)
Parental Education	45.4% of mothers and 48.7% of fathers of young children had obtained postsecondary education
Level of Income	84.4% of all families with young children are living above the post-tax low-income cut-off
Parental Depression	88.8% of parents did not display signs of depression
Tobacco Use During Pregnancy	19.4% of mothers smoked during pregnancy
Alcohol Use During Pregnancy	14.5% of mothers consumed alcohol during pregnancy
Parental Smoking	72.6% of the person most knowledgeable about the child and 70.4% of their spouses did not smoke at all
Family Functioning	89.1% of parents indicated positive functioning among family members
Positive Parenting	88% of parents indicated positive interaction within the family
Reading by Adult	69.7% of children are read to daily or several times per day
Neighbourhood Cohesion	84.9% of parents indicated a sense of cohesion with the neighbourhood
Families with Children Living in Core Housing Need	36% of children living in rental households and 7% of children living in owner households were living in core housing need (1996)

Future Government of Canada reports will monitor trends in the indicators presented above. As data become available, additional indicators that further enhance the understanding of young children's well-being may be included in future reports.

ANNEX A – ACRONYMS USED IN THE REPORT

APS	Aboriginal Peoples Survey
CHIRPP	Canadian Hospitals Injury Reporting and Prevention Program
ETS	Environmental Tobacco Smoke
HALS	Health and Activity Limitation Survey
Hib	Haemophilus influenzae-b
LICO	Low-Income Cut-Off
MSD	Motor and Social Development
NACI	National Advisory Committee on Immunization
NCA	National Children's Agenda
NLSCY	National Longitudinal Survey of Children and Youth
OECD	Organisation for Economic Co-Operation and Development
PALS	Participation and Activity Limitation Survey
PMK	Person Most Knowledgeable about the child
PPVT-R	Peabody Picture and Vocabulary Test – Revised
UEY	Understanding the Early Years

