Prince Edward Island
CANADA

Premier's Council on Healthy Child Development

Annual Report on Children 2002-2003

Third Annual Report on Children

2002-2003

Prepared by the Children's Secretariat for the
Premier's Council on Healthy Child Development

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Our Vision

Children in Prince Edward Island will thrive in an atmosphere of love, care and understanding. They will be valued as individuals in childhood and will be given a sense of hope and pride in themselves and our Island, as well as opportunities to reach their full potential as adults.

Respected and protected, Island children will respect and protect the rights of others. Valued, nurtured and loved, they will grow up able to contribute to a society that appreciates literacy, diversity, supports the less able and shares its resources.

Given the opportunity to develop their physical, creative, intellectual, emotional, social and spiritual capacity to the fullest, children in Prince Edward Island will become tomorrow's successful and enthusiastic parents, caregivers, workers and citizens.

....For Our Children: A Strategy for Healthy Child Development

Table of Contents

Background 1

I. For Our Children ... A Strategy for Healthy Child Development 2

II. Early Childhood Development Initiative 15

III. Early Childhood Education and Care 27

IV. Indicators of Child Well-being 41

Appendixes

Appendix 1 Technical Notes to the Indicators 79

Appendix 2 Children's Working Group 87

Background

Research confirms what parents have always known – children who are provided the best start in life grow up to be caring and nurturing adults. Our children are our future. In order to create a society and an economy that is strong and healthy, it is our responsibility to optimize the development of our children.

In Prince Edward Island there is a growing awareness and appreciation for the strong and lasting impact of early childhood experiences. Families, communities, organizations, governments and business are working to support young children and their families through a wide range of activities. This Annual Report on Children 2002-2003 provides information on some of those efforts that are taking place every day.

The ***Premier's Council on Healthy Child Development*** is a group of Islanders who serve in an advisory capacity to the Premier on issues affecting children in Prince Edward Island. Council members are representative of the diversity in the Island population. Members are appointed based on their individual strengths and expertise in matters related to healthy child development in the prenatal to early school years period.

Each year the council uses this Annual Report on Children to share with Islanders the many ways children's issues are being addressed on PEI. The annual report also shares information on the Healthy Child Development Strategy and its partners, federal-provincial agreements which focus on children and indicators of child well-being.

I. For Our Children ... A Strategy for Healthy Child Development

A Strategy for Healthy Child Development was presented to the Premier in the fall of 2001. Developed through extensive community consultation, the strategy focuses on improving outcomes for children from the prenatal period to eight years of age.

The strategy aims to ensure that all children on PEI will be ...

- ***safe and secure*** – children's basic needs for food, shelter, clothing and a safe physical environment will be met and they will be protected from abuse, neglect, discrimination, exploitation and danger;

- ***healthy*** – children will be as physically, emotionally and spiritually healthy as possible, with strong self-esteem, coping skills and enthusiasm;

- ***successful at learning*** – children will have opportunities to reach their full potential for good physical, social and artistic development, language, literacy, numeracy and general knowledge needed for a successful transition into adult life; and

- ***socially engaged and responsible*** – children will be helped to form stable attachments to nurturing adults, including strong supportive relationships within and outside their families and they will be encouraged to develop an understanding of the rights and responsibilities of belonging to a wider community and to understand the consequences of their choices.

The Healthy Child Development Strategy recognizes our collective role in helping children to reach these goals. Government provides leadership, but the involvement of communities, businesses and families is essential to ensure its success.

Children's Secretariat

Consistent with the collaborative spirit of the Healthy Child Development Strategy, five government departments have been working together to form the **Children's Secretariat.** The departments involved are: Health and Social Services, Education, Community and Cultural Affairs, Office of the Attorney General and Development and Technology.

Through the secretariat, these five departments work together to share information and develop partnerships between departments and sectors, to connect with community organizations, to promote the importance of the early years within government, to monitor provincial activities for children, and to collaborate with other provincial governments and the federal government.

Why these five departments?

Each department supports children and families in its own way. Each department contributes to children's well-being by promoting children's safety and security, good health and success at learning and by supporting communities.

- The **Department of Health and Social Services** supports children and families through its many health-related and financial programs.
- The **Department of Education** is a leader in ensuring equitable opportunities for lifelong learning.
- The **Department of Development and Technology** helps parents support their families through economic development and employment initiatives and builds community capacity through its community development bureau.
- The **Department of Community and Cultural Affairs** promotes culture and heritage and encourages Islanders to be physically active through sport and recreation activities.
- The **Office of the Attorney General** works to promote safe communities and to support families through the family justice system.

When these departments collaborate, an immense range of knowledge and experience is shared. By working together, these departments are able to reach a common understanding of how their respective goals can be jointly achieved.

Children's Working Group

In Prince Edward Island, a "network of networks" links individuals, organizations and coalitions who work to improve child outcomes. This network forms the PEI Children's Working Group and includes members from community-based networks, academia and government. Each of the community networks is based on the key areas for action from the Healthy Child Development Strategy.

Each year the Children's Working Group prepares an Action Plan which outlines priorities for children in the year ahead. The PEI *Partnerships for Children* initiative was identified in the 2002-2003 Action Plan on Healthy Child Development.

PEI Partnerships for Children promotes healthy outcomes for young children on PEI. In addition to supporting children and families, the initiative was intended to strengthen community-based networks. Through PEI Partnerships for Children, each working group network was allocated funding for initiatives which support the key action areas outlined in the Healthy Child Development Strategy.

The **Children's Working Group** networks and their respective projects in 2002-2003 are listed as follows:

- The ***Pregnancy, Birth and Infancy*** network developed recommendations for a social marketing plan and created a social marketing resource to increase the number of pregnant women attending prenatal classes and utilizing prenatal resources in the community.

- The ***Family Literacy*** network presented a one-day workshop for early childhood educators on Enhancing a Child's Speech and Language and Enhancing Family Literacy on PEI through Early Childhood Educators.

- The ***Childhood Injury Prevention*** network increased the appropriate car/booster seat use through raising parent and caregiver knowledge on how best to seat their kindergarten-aged children in a vehicle.

- The ***Exceptional Needs*** network learned and shared more information regarding developing play, social and communication skills in preschool children with exceptional needs and worked with early childcare centres to help further enhance opportunities for children with exceptional needs to develop their play, social and communication skills in an integrated setting.

- The ***Children's Mental Health*** network supported the continuation of the I'm Thumbody program on PEI schools. I'm Thumbody is an early childhood mental health program which promotes personal health and successful relationships and is delivered in Grade 3 classrooms.

- The ***Acadian and Francophone*** network provided support to new French language early childhood centres in four Acadian and francophone regions of PEI.

- The ***Screening and Assessment*** network hosted the Wonder Years Conference which brought best practice information to parents and professionals involved with care, assessment and management of children with Down's Syndrome. The conference addressed four different areas: medical, speech and hearing, education and education transition issue and parent support/advocacy.

- The ***Healthy Lifestyles*** network raised awareness around the importance of healthy eating and physical activity in children from birth to eight years of age and their parents and teachers through active living mascot visits to early childhood and family resource centres, posters in the centres and handouts for parents.

- The ***Parent Support*** network provided two, two-hour parent workshops on how to ease a child's transition into Grade 1 and maximize the likelihood of success in school. The network also prepared a facilitator resource manual for future workshops.

- The ***Early Childhood Care and Education*** network developed wage scales for early childhood educators, program staff and special needs assistants consistent with the level of certification, experience and duties, and developed an implementation strategy and detailed costing.

- And together, ***Children's Working Group Networks*** collaborated to develop messages which support the key areas for action of the Healthy Child Development Strategy and communicated these to the Island public via various local media. The networks' commitment to healthy child development and their spirit of collaboration was demonstrated throughout the course of this project.

Highlights 2002-2003

In 2002-2003, numerous special events occurred which support children and families.

The First Annual **Healthy Eating Week** was held in March 2003. During this week, the Healthy Eating Alliance prepared Healthy Eating Survival Kits which included information on healthy eating and physical activity for children, recipes, meal planners and grocery lists for parents. Kits were distributed through Access PEI locations across PEI.

Family Literacy Day was celebrated on Monday, January 27 to raise awareness of the key role of families in helping children develop literacy skills and a love of learning. Literacy is the foundation of lifelong learning.

A Path to Healing and Prevention – Fetal Alcohol Syndrome and Alcohol Related Effects Conference was held in February 2003. The conference, coordinated by the Mi'kmaq Family Resource Centre, included experts from across Canada and attracted more than 200 participants.

Congratulations are extended to Islanders Alice Taylor and Ron Stanley who were each awarded a **Canadian Child Care Federation's *Golden Jubilee Award.*** Alice was recognized for her contributions, care and commitment to the Early Childhood Care and Education sector and Ron was recognized for his work in child welfare.

Prince Edward Island signed the **Multilateral Framework on Early Childhood Education and Care** in March 2003. This five-year agreement provides funding to provinces for improving access to affordable, quality early learning and child-care programs and services which are provincially regulated.

Child Find PEI was presented with a Premier's Crime Prevention Award in 2002 for their significant contribution to crime prevention on PEI. Founded in 1988, Child Find PEI helps in the search and recovery of missing children. Their trained and dedicated volunteers teach and reinforce messages of safety and prevention to families, educators, caregivers and the public across the province of PEI. Child Find PEI focuses on the prevention of abductions.

The ***Smoke Free Places Act*** received royal assent in the fall of 2002. This act provides a legislative framework to protect the public and workers from the harmful effects of second-hand smoke by creating smoke-free work and public environments.

Reaching Our Goals

As reaching the goals of the Healthy Child Development Strategy is a responsibility of all Islanders, this section of the report provides some examples of how Islanders are supporting the strategy goals.

All children in Prince Edward Island will be safe and secure.

- PEI schools continued to provide programs which address **sexual abuse and bullying prevention**. Five additional schools focussed their school-based staff development initiatives on developing a positive and supportive school environment for staff, students and their families through the development of a code of conduct.
- With funding support from Justice Canada, a Special Projects Officer with Victim Services, PEI Office of the Attorney General, secured arrangements for **child-friendly waiting rooms in the Sir Henry Louis Davies Supreme Court building** in Charlottetown. These arrangements allow the child victim/witness to enter the courtroom through an entrance away from the accused and the public. The PEI Police Association also provided financial assistance to purchase age-appropriate games, toys and activities. These are now available at both the Summerside and Charlottetown courthouse locations.
- A **play on domestic violence** was presented to students of six senior high schools in the Eastern School District. The RCMP, Victim Services, Transition House Association and Child and Family Services worked together to organize this activity.
- **Internet safety sessions for parents** have been provided through partnerships with the PEI Home and School Federation, RCMP and the Department of Education. Internet Safety Sessions were also available to the general public during Information Technology Week.
- In November 2002, Kids R' First Family Resource Centre and staff from East Prince Health organized a **car seat safety clinic** to inform parents of proper car seat set-up in an effort to reduce injuries from accidents. Other partners included Kids West, Highway Safety, Child and Family Services and community volunteers.

All children on PEI will enjoy good health.

- The Department of Health and Social Services and the four health regions established **a review committee for age 0-6 public health nursing screening programs** to ensure best practices in screening programs, prevent duplication of services, and ensure that educational resources for parents are up-to-date and effective.

- The **PEI Tobacco Reduction Alliance** offers self-help materials for quitting smoking specifically for pregnant women through Public Health Nursing offices across PEI.

- The Smoke Free Homes Committee of the PEI Tobacco Reduction Alliance continued its activities to reduce children's exposure to tobacco smoke in their homes by launching the **Let's Take It Outside Contest** in the fall of 2002. This contest encouraged Islanders to make their homes smoke-free. More than 5,000 households took the pledge to keep their home smoke-free for six months. Nine communities were awarded prizes for registering the largest percentage of their households — Congratulations to Wellington, Tignish, Tyne Valley, Argyle Shore, Mount Stewart, Tracadie Cross, Morell, Cardigan and Souris.

- The PEI Active Living Alliance's **SummerActive Crew** was well received by children across the province in summer 2002. Crew members promoted physical activity through information and activities. The SummerActive program also partnered with the Canadian Cancer Society to deliver a sun-safety message.

- The **PEI Healthy Eating Alliance** is a multi-sector group of individuals from community organizations, university faculties and government departments sharing a concern for children's health and a commitment to improving the eating habits of children and youth. This very active alliance initiated a wide variety of activities in 2002 including:
  - preparing numerous presentations and media interviews through newspaper, radio and television;
  - preparing Nutrition Tips for easy nutritious lunches to be included for school newsletters;
  - partnering with the Canadian Living Foundation/Breakfast for Learning to become the adjudicating body for school breakfast and snack programs;
  - helping school breakfast and snack programs recruit and train volunteers, obtain sponsorship and implement best practices in their programs; and
  - implementing a pilot project in three elementary schools across the Island to promote increased fruit and vegetable consumption among children and youth.

- The **Prince Edward Island Sport Strategy** was released in the fall of 2002. One of the goals of the five-year strategy is to increase participation in sport and recreation at all levels and encourage lifelong participation.

All children on PEI will enjoy good health … continued

- In support of educating parents and children on the value of physical activity, the Department of Community and Cultural Affairs distributed the new and colourful **Canada's Physical Activity Guide for Children** in all kindergartens and elementary schools.
- The Adventure Group, through its **Transformative Parenting Project**, began considering how restorative justice principles can be used in dealing with conflict in the family. The project aims to encourage social development in children and transform relationships in families and communities by supporting parents in disciplining children in ways which encourage children to take responsibility for repairing the harm they have done to others, learn empathy from those they have harmed and reduce the potential for future harm.
- **AIDS PEI** led a committee which worked to encourage pregnant women and those contemplating pregnancy to have HIV/AIDs testing.
- The **Kings Region Pre-school Assessment Team** participated in an evaluation which confirmed that the Montague-based team provides a valuable assessment service for children with identifiable delays in their growth and development. Evaluation results indicate that 100 per cent of parents were satisfied with the assessment and follow-up they received. A similar assessment team has been established in Souris with the support of the Eastern Kings Foundation Inc.

All children on PEI will be successful at learning.

- In a partnership between the **Provincial Library Service, TD Financial group and the Canadian Children's Book Centre**, a copy of a book by Canadian author Sharon Jennings was offered to all Grade 1 students visiting their public library during the Canada-Wide TD Canadian Children's Book Week.
- **Little Expressions Mean a Lot**, a program piloted in Kings Health Region, was expanded Island wide. Now all Islanders are able to benefit from this community capacity building project which promotes education and awareness in the area of speech and language development.
- To meet the needs of children with autism and their families, the **Pre-school Autism Early Intervention Program** hired two pre-school autism specialists to work with the early intervention coordinator.
- **Family Literacy Day** is celebrated each year to raise awareness of the role of families in helping children develop literacy skills and a love of learning. To celebrate, a Carousel of Family Literacy Activities was held for parents and children on January 25, 2003. Activities included storytelling, puppet shows and book draws. The PEI Literacy Alliance, the Confederation Centre Children's Library and Frontier College Students for Literacy@UPEI sponsored the event.
- The **Kindergarten pilot project** was successful and has expanded across PEI. In its first year, 97 per cent of eligible children were enrolled in the publicly funded, community-based program.
- The **Early Childhood Development Association** continues to work hard to serve the needs of PEI early childhood educators. With assistance from the departments of Health and Social Services and Education, a part-time executive director was hired to support the early childhood sector. The association has also developed a Community Resource Centre filled with materials relevant to the early years in a child's development and has begun circulating a quarterly newsletter to all association members. The sector also began discussions with the Union of Public Sector Employees (UPSE) to consider options for their work force.
- **Understanding the Early Years** (UEY) is a project of the Early Childhood Development Association (ECDA) of PEI. In 2002-2003, UEY connected with Islanders through a knowledge exchange strategy that matches UEY learning with the knowledge and experience already present in PEI. UEY learning has been customized for various audiences and has been communicated by UEY staff, members of the Community Advisory Committee, and trained 15 volunteer UEY Champions.

All children on PEI will be successful at learning … continued

- Adult learners are very outspoken when describing their reasons for returning to school. Many say that they want to set a good example for their children so they can understand the importance of being successful in school. The **Adult Basic Education Program** continues to be an effective and family supportive activity that more than 1,200 adult Islanders participate in annually. **Workplace Education PEI** continues to provide literacy and learning opportunities in workplaces across PEI. Participants in these programs recognize the significance of learning opportunities for them as individuals and for their families.

- The PEI Literacy Alliance, in partnership with the Department of Education, the school districts, and the Government of Canada, continues to run the **Summer Tutoring Program for Kids**. In July and August 2002, 659 elementary school-aged children participated in the program delivered by 22 tutors. This province-wide program has gained an excellent reputation as a positive literacy intervention that helps children with reading difficulties maintain and/or increase their reading levels over the summer. The tutors are university students, with a majority of those students enrolled in the education program at UPEI. The program is an excellent opportunity for the future classroom teachers to develop skills and empathy in helping children who have literacy difficulties. The tutors also have an opportunity to learn more about family literacy challenges faced by Island children.

- **Literacy development in the early school years** continues to be a priority for Island schools. Workshops, professional development opportunities and other resources on early literacy help Island teachers respond to the needs of their students.

- **Hearing Education Auditory Resources (HEAR) teachers** continued to offer in-service sessions and on-going support to early childhood educators and teachers and to help caregivers and peers outside of the family understand how to best manage each child's hearing loss. In 2002, HEAR organized a parent panel discussion providing a personal and powerful presentation that helped professionals understand how families are affected by hearing loss. HEAR also supported parents' meetings and social events throughout the year.

All children on PEI will be socially engaged and responsible.

- **Francophone child-care services** were expanded and enhanced in West Prince, Summerside, Rustico and Charlottetown in September 2002.
- The **Community Development Bureau** through the Department of Development and Technology supports families and communities by working with local community groups to build capacity.
- Brookvale Provincial Ski Park hosts an **Annual Festival of Colours** which organizes fun events for the whole family, including food, music and lots of activities for children. The festival is a great way to experience the outdoors on PEI.
- The PEI Women's Institute and the Early Childhood Development Association have partnered to develop **Story Sacks to support the Fair Play Kids project**. Each sack contains puppets and other visual materials associated with the Kids Play Fair stories. With these materials, children are able to act out the stories as they read them. Story Sacks have proven very successful as family literacy tools on PEI.
- Through the **Integrated Projects Group**, Island schools are using various forms of technology to share and celebrate cultural stories and experiences through collaborative projects. For example, elementary students from Miscouche, Lennox Island and Hay River, Northwest Territories collaborated to explore their respective cultures. As well, educators from all levels have collaborated and shared cultural projects, such as the international cultural stories from a variety of students in Island schools.
- Elementary students in Alberton are being encouraged to become involved in their community. **Grades 3 and 4 students from Alberton Elementary** visited Maplewood Manor every two weeks for a reading program with the residents.
- The **Summerside YMCA**, supported by donations from the community and local businesses, provided school supplies for students receiving services from Child and Family Services. This partnership helps support a positive beginning to a new school year for many children.

II. Early Childhood Development Initiative

In September 2000, Prince Edward Island joined with other provinces and territories and the federal government in a commitment to support families and communities in their efforts to ensure that young children can fulfil their potential to be healthy, safe and secure, ready to learn and socially engaged and responsible. Through this Early Childhood Development Initiative (ECDI), the federal government has committed to an annual transfer of funding to provincial and territorial governments over a five-year period.

Funding received through the ECDI is intended to introduce, improve and/or expand early childhood development programs and services. On Prince Edward Island, a range of programs already exists which supports early childhood development. The ECDI provides an opportunity to strengthen existing programs and invest in new ones.

The First Ministers' Agreement on Early Childhood Development includes four key areas: healthy pregnancy, birth and infancy; early childhood development, learning and care; parenting and family supports; and community supports. Governments' efforts within this framework focus on any or all of these areas.

In 2002-2003, Prince Edward Island received $1.7 million for investments in early childhood development which were integrated with the provincial Healthy Child Development Strategy. Specifically, PEI made the following investments in three key areas:

Early Childhood Development, Learning, and Care

- Measuring and Improving Kids' Environments (MIKE)
- Grants to early childhood centres to support children with special needs
- Publicly funded, community-based kindergarten

Parenting and Family Supports

- Disability supports for children from birth to age six
- Best Start home visiting program
- Positive Parenting from Two Homes – Children's Program
- Child Care Subsidy Program

Community Supports

- Healthy Child Development Strategy – nurturing a community development approach
- Partnerships for Children

1. Early Childhood Development, Learning and Care

A. Measuring and Improving Kids' Environments (MIKE)

The Measuring and Improving Kids' Environments (MIKE) project provided program support, training and development to early childhood centres across the province. A two-year pilot initiative, MIKE commenced in August 2001 and concluded its pilot phase in June 2003. The project provided an opportunity to begin to objectively measure quality in licensed centres, to target the supports needed to improve environments, and to measure the impact of those supports.

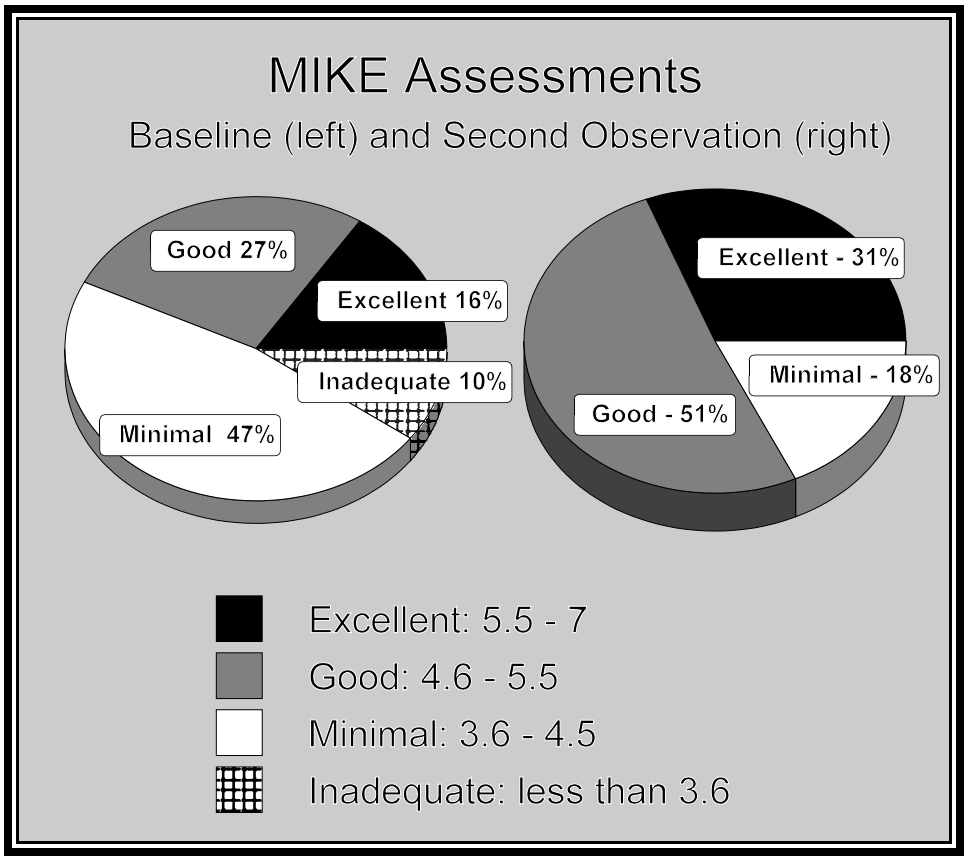
MIKE is a shared initiative of the Children's Secretariat (Department of Health and Social Services) and the Early Childhood Development Association of PEI. The Department of Health and Social Services provided funding for the project activities, supervision of consultants and liaisons with government and national initiatives. The Early Childhood Development Association of PEI maintained communication with association members, administered the project and liaised with other early childhood initiatives in the community.

The first phase of the project (2001-2002) focussed on licensed full-day early childhood centres providing inclusive programs for children with special needs. The second phase (2002-2003) expanded the project to include all licensed early childhood centres. As well, follow-up assessments were carried out during the second phase, in order to measure the impact of the efforts to improve quality.

The goal of the MIKE program is to increase the levels of quality in licensed early childhood programs across PEI. In order to accomplish this goal, MIKE focuses on increasing the capacity of staff in early childhood centres to provide higher quality services for all children within their programs. The pilot project promoted and supported best practices of early childhood educators in the delivery of inclusive and quality child-care services to Island children.

Centre directors and staff were introduced to the Early Childhood Environment Rating Scale – Revised (ECERS-R) assessment tool and invited to participate in the program. Staff of the MIKE program completed assessments and shared the results with directors and staff. Together, plans were developed to address areas which needed improvement and MIKE staff provided advice and support as centres worked to improve the early childhood environment.

Improvements to quality were measured through planned followup assessments. Plans which addressed improvements were revised, training identified and peer networks within regions created. Results of follow up assessments demonstrated the success of these interventions.



All licensed full-day early childhood centres on PEI were targeted for this project. While participation is voluntary, approximately 95 per cent of centres (52 centres) are involved in the program.

The budget allocation for 2002-2003 was $50,000.

B. Grants to Early Childhood Centres to Support Children With Special Needs

Special needs grants provide additional funding to licensed early child development centres in order to support inclusive programs for children with special needs. Typically, this funding is used to employ additional staff to lower the child-staff ratio at the centre, allowing all staff to be able to provide for individualized programming for the child with special needs.

The goal of the Special Needs Funding Program is to support the inclusion of children with special needs in licensed early child development settings. Program objectives are:

- to support licensed centres with appropriate resources to provide individualized programs with quality early childhood education environments;
- to encourage communication among parents, centre staff and other professionals involved in working with the child; and
- to provide for accountability on the part of licensed child development facilities for funded programs.

Funding is provided on behalf of children with special needs who are attending licensed early childhood development centres. For the purpose of this grant, a child with special needs is defined as one who, in order to attain the usual development goals, requires additional and/or specific types of stimulation/care. Children who would normally fall into this population include those with issues relating to: mobility, cognition, development delay, vision or hearing loss, speech, behavioural issues and children who have multiple disabilities. Since parents are not income/needs tested for eligibility for these support services, all families are eligible for participation in the program.

During 2002-2003, funding was provided to 45 early childhood programs on behalf of 205 children and their families. This represents a 33 per cent increase in the number of children who are able to benefit from additional supports in their early childhood centres.

The Department of Health and Social Services is responsible for the administration of the Special Needs Grant program. In 2002-2003, the budget allocation for this program was $867,300. Of this, $300,000 was allocated from the Early Childhood Development Initiative. Actual expenditure exceeded budget allocations ($1,060,134).

C. Child Care Subsidy Program

The Child Care Subsidy Program is a provincial program designed to assist parents with the cost of licensed early learning and child-care programs. The goals of the Child Care Subsidy Program are:

- to support parents, who meet established social and financial criteria, in paying for the cost of licensed early learning and child-care programs;
- to provide timely services to prevent parents from becoming "persons in need"; and
- to provide timely information to both applicants and early childhood centres concerning the approval of applicants.

The program provides subsidies to parents based on social and financial criteria. Social criteria includes parents employed or in a training program (if the funds for child-care expenses are not available through the training program), children in need of protection, medical needs of the parent, and children with special needs. Financial eligibility is determined by a Sliding Scale Income Test which considers family size and net monthly income; families may receive full or part subsidy.

This provincial program is administered through four regional health authorities, with the Department of Health and Social Services responsible for policy development. Funding is provided on behalf of children aged 10 and under who are attending licensed early learning and child-care centres.

In 2002-2003, a total of $3,256,092 was spent on this program. Of this total, $40,000 was invested using funds from the Early Childhood Development Initiative. This represents a 1.2 per cent funding increase over the previous year.

D. Publicly Funded Community-based Kindergarten

PEI's publicly funded, community-based kindergarten program was introduced in September 2000. As part of the early childhood system, kindergarten on PEI is privately owned and operated. Throughout the three-year implementation phase the provincial government, under the leadership of the Department of Education, continues to develop curriculum and policy that reflects and supports this unique approach to kindergarten.

The goal of this initiative is to fund a core community-based program, thus enabling more children to attend kindergarten and providing consistent curriculum for Island children. In 2002-2003, children who were five years of age as of January 31 of the current school year were eligible for kindergarten.

The departments of Education and Health and Social Services share responsibility for kindergarten. The Department of Education is responsible for the development and funding of a core kindergarten program and for in-service training related to the kindergarten curriculum. Kindergarten programs are licensed as early childhood centres according to PEI's *Child Care Facilities Act*. The minister of Health and Social Services is responsible for this act. The Department of Health and Social Services continues to be responsible for supports for children with special needs and certification of early childhood educators, while both departments share responsibility for licensing and program inspections.

There were 90 community-based kindergarten sites during the 2002-2003 school year. A total of 1,605 children attended these programs. Based on PEI's birth rate, 97 per cent of children eligible for kindergarten are attending. Attendance increased 12 per cent the first year kindergarten was publicly funded and has remained constant.

In 2002-2003, the second year of implementation of this program, additional investments were made as part of the Early Childhood Development Initiative. During this year, a one-time Kindergarten Resource Grant enabled licensed centres to purchase non-consumable toys, equipment and resources to support the curriculum.

Expenditures for the kindergarten program in this fiscal year totalled $3.2 million. Of this amount, $647,000 was invested from the Early Childhood Development Initiative.

2. *Parenting and Family Supports*

A. Best Start Home Visiting Program

In November 2002, the Department of Health and Social Services entered into an agreement with the National Crime Prevention Centre and CHANCES Family Resource Centre to support the province-wide introduction of universal infant screening and followup home visiting. This project builds on a three-year pilot project based in the Queens region.

The goal of the Best Start program is to maximize the development of young children and their families, particularly those experiencing conditions of risk. Public health nurses in all health regions offer screening and followup assessment to all families of newborns. For those families who are determined to be facing challenges, referrals may be made to the home visiting program. Home visiting is available for up to three years, with diminishing frequency of visits from year to year. Participation in any aspect of the program is voluntary. The program targets all newborns and their families, particularly young, single parents and youth at risk.

In 2002-2003, public health nurses completed screening of 635 families with newborns. Of all families screened, 25 per cent screened positive. Of those screened positive, 41 per cent agreed to follow through with a full assessment. Of the 62 positive assessments, 57 families agreed to participate in the home visiting program.

Participation rates for the 2002-2003 year include those families who were screened in during the pilot phase, as well as new families who were assessed after the program received provincial funding. In all, 174 families and 261 children were involved with the program during this year.

Ongoing program evaluation is being conducted by the Canadian Research Institute for Law and Family.

In 2002-2003, $119,000 was allocated from the Early Childhood Development Initiative.

B. Disability Supports for Children from Birth to Age Six

The PEI Disability Support Program (DSP) is a social program with a financial component. Introduced in October 2001, the program is designed to assist Islanders (children and adults) who have a qualifying disability (physical, intellectual, neurological) to overcome barriers, to attain a satisfactory quality of life, and to strive to achieve financial independence.

Within the overall structure of the DSP, supports are being offered for children from birth to six years of age and their families. The DSP may assist children with disabilities by offering support to them and their parent(s) or guardian(s). The program assists families with extraordinary child-rearing needs directly related to the child's disability and offers supports and referrals to other agencies where complementary services may be obtained.

In 2002-2003, 91 children from birth to six years of age and their families received supports from this program. In previous years, children and their families received varying levels of support from the Family Support Program. The DSP has broadened the scope of possible supports and the level of financial support.

The Department of Health and Social Services is responsible for this program and Disability Support Units are now in place in each health region. Disability support workers are specifically trained to work with children and adults with disabilities and their families. They work as partners with individuals and families to develop a support plan to meet disability-specific needs.

A total of $300,000 was invested in this program in 2002-2003 through the Early Childhood Development Initiative.

C. Positive Parenting From Two Homes – Children's Program

Established in 1999, Positive Parenting From Two Homes is part of the family law section of the Office of the Attorney General. The program is for parents who are concerned about the effects of separation, divorce and parenting from two homes and the resulting conflict and effects on children. This also includes parents who have never lived together. The program is offered approximately 12 times a year throughout the province. The format consists of two three-hour sessions presented by trained facilitators. Parents attend separate sessions and are screened. Topics include: positive parenting, other people in children's lives, children's grief, adult's grief, what children need, developmental ages and stages of children, conflict resolution, parenting plans, mediation, family violence and how to develop a business-like relationship with the other parent.

An evaluation component by an independent researcher demonstrates the need and effectiveness of the program in terms of changes in adult behaviour resulting in changes in children's well-being and adjustment.

Positive Parenting From Two Homes "for kids" is an off-shoot of the parent's program and is the result of requests from parents for a program to assist children through the changes and conflict resulting from family breakup or having two homes. The program provides children with information to help them cope with their changing family. Topics include: what is a family, changes that occur when there is separation/divorce, how it affects the child individually, court procedures, future concerns and conflict resolution. The program is presented in four evenings over four consecutive weeks by trained facilitators.

In 2002-2003, $25,000 was invested in this program through the Early Childhood Development Initiative.

3. *Community Supports*

A. Healthy Child Development Strategy: Community Development

The Healthy Child Development Strategy is a multi-departmental initiative focused on improving outcomes for children on Prince Edward Island. The strategy builds on the successes of programs, services and community supports, and encourages partnerships among community, business and government.

During provincial consultations prior to the launch of the strategy, Islanders emphasized the need for community involvement in the development of policy, programs and services for children and families. They stressed that the success of the strategy depends on community ownership. However, Islanders also reported that they wanted Government to provide leadership in this endeavour.

In order to ensure a role for community, the implementation of the Healthy Child Development Strategy is monitored by the Premier's Council on Healthy Child Development. Council members are individuals from across PEI who represent a variety of experiences and backgrounds.

As well, the Children's Working Group (CWG) is integral to the implementation of the goals and objectives of the strategy's Key Areas of Action. Members of the CWG include representatives chosen by the community, and government representatives from each of five provincial departments involved in the Healthy Child Development Strategy. These government representatives work together on the Children's Secretariat.

The Early Childhood Development Association (ECDA) of PEI coordinates the *Understanding the Early Years* project for the province. The Children's Secretariat has partnered with the ECDA on a joint workplan in order to promote community action in meeting the goals and objectives of the Healthy Child Development Strategy.

Objectives for the community development work of the strategy include:

- strengthening and building on current partnerships;
- providing opportunities for discussion and networking for organizations, community groups and government departments;
- sharing information with communities across PEI; and
- encouraging community action for healthy child development.

Efforts in community development have been directed to community-based organizations working on behalf of young children and their families; parents; business; community and municipal leaders; and special populations, including francophone and aboriginal populations.

There are five provincial government departments involved with the Healthy Child Development Strategy; these include:

- Department of Health and Social Services (lead);
- Department of Education;
- Department of Community and Cultural Affairs;
- Department of Development and Technology; and
- Office of Attorney General.

As well, the Premier's Office has established a Premier's Council on Healthy Child Development. The council's role is to monitor the implementation of the strategy, and to advise the Premier on issues related to the healthy development of children in PEI.

Community development investments have supported events such as the Premier's Council's Think Tank, meetings of the Children's Working Group, network meetings, provincial network conference, community meetings and presentations, etc.

In partnership with Understanding the Early Years, the community development efforts are being evaluated by Social Research Development Corporation.

In 2002-2003, $110,000 was invested in this initiative through the Early Childhood Development Initiative.

B. PEI Partnerships for Children

PEI Partnerships for Children was a new initiative in 2002-2003 to promote healthy outcomes for young children on PEI. Through the initiative, each network of the Children's Working Group was allocated $10,000 for initiatives which support the key action areas outlined in the Healthy Child Development Strategy. The purpose of the initiative was two-fold – to improve outcomes for children on PEI and to strengthen the community-based networks.

Funding was allocated using a community development approach. The process was non-competitive with submissions for funding required to demonstrate how the project would address the strategy objectives and how the network partners would work together to implement the initiative. Members of the Children's Secretariat supported the work of their community-based colleagues in developing partnerships as part of the application process.

Partnerships for Children supported a range of activities, including social marketing and public awareness, the development of a salary grid for early childhood educators, programs for children, and workshops and conferences for parents. Initiatives addressed prenatal education, social skills for children with exceptional needs, children's mental health, active living, literacy, use of car seats and booster seats, and information for parents to support their children during the transition from early childhood to the school system.

All networks collaborated on a public education campaign to communicate key messages from their various networks. Over a period of two weeks, a coordinated newspaper and radio campaign was implemented across PEI. The networks' commitment to healthy child development and their spirit of collaboration was demonstrated throughout the course of this project.

In 2002-2003, $110,000 was allocated to the Partnerships for Children initiative through the Early Childhood Development Initiative.

III. Early Childhood Education and Care

Canada's Multilateral Framework Agreement on Early Learning and Child Care

In March 2003, federal/provincial/territorial Ministers of Social Services agreed on a framework for improving access to affordable, quality, provincially and territorially regulated early learning and child-care programs and services. The objective of the initiative is to further promote early childhood development and support the participation of parents in employment or training by improving access to affordable, quality early learning and child-care programs and services. Prince Edward Island participated actively in developing and supporting the Multilateral Agreement and continues to work toward its implementation.

Through the Multilateral Framework Agreement, the Government of Canada transfers funds on an annual basis to Prince Edward Island in order to advance the objective as described above, and to build on the significant provincial investments already made in early learning and child-care programs and services.

Multilateral Framework Agreement on Early Learning and Child Care Prince Edward Island				
2003-2004	**2004-2005**	**2005-2006**	**2006-2007**	**2007-2008**
$110,000	$652,000	$973,000	$1,293,000	$1,502,000

As part of this agreement, PEI has agreed to publicly report on a baseline of programs, services and expenditures.

History of Early Childhood Education and Care on PEI

Prince Edward Island has always been characterized as a rural economy, with close-knit communities and large extended families. While evidence of early childhood programs in Prince Edward Island can be traced back to the early 1800s, the emergence of child care as a formal, licensed system was not seen until the 1960s. The first kindergarten was started in Charlottetown in 1842 and closed in 1858. Formal systems of child care wherein caregivers were paid for their services were simply non-existent during the 1940s and 1950s in PEI.

It was not until the 1960s that Islanders saw the beginning of the types of child-care programs that are in existence today. Kindergarten programs began to develop during this time and the emergence of "child care," or full-day, early childhood programs, grew out of this kindergarten movement. Centres in rural PEI began to develop in the 1969-1971 period.

In 1971, Government designated the Department of Social Services as the agency responsible for the regulation of child-care facilities, and for the management of any public funds that would be appropriated for day-care purposes. In 1972, a two-year post-secondary diploma program in Early Childhood Education was initiated at Holland College on its Charlottetown campus, with an on-site early childhood program.

Legislation to regulate early childhood centres was first enacted in 1973. Regulations to the *Child Care Facilities Act* were introduced in 1978, following extensive consultation with the child-care sector.

In the spring of 1974, a provisional committee of operators of licensed child-care facilities was established to organize the Early Childhood Development Association (ECDA) of Prince Edward Island. The ECDA was incorporated as a non-profit organization, and continues to be the only professional association of early childhood educators in the province.

Development of Programs and Services

In 1977, Government introduced the Child Care Subsidy Program to subsidize the cost of child care for eligible parents. Prior to this, Government funded all operational costs for six centres, while parents in other areas had no access to support. The new subsidy program was intended to provide equitable access to financial support for child-care fees for eligible families across PEI.

The Department of Health and Social Services introduced the "Special Needs Policy" in 1982. This policy allowed for higher per diem rates for children with special needs who were attending licensed early childhood programs, to encourage centres to provide more individualized programming for children who needed additional supports. Parents were income tested, and funding was provided through the Child Care Subsidy Program.

During 1985 and 1986, the Department of Health and Social Services coordinated province-wide consultations in preparation for revisions to the *Child Care Facilities Act and Regulations*. The revised *Child Care Facilities Act* provided clear definitions of "child," "child care," and "child-care facility," defined the role of the Child Care Facilities Board, and allowed for a more streamlined, effective appeal procedure. Revised regulations addressed a broad range of aspects of child care, including supervision, behaviour management and definition of program requirements. For the first time in PEI, staff training requirements were introduced.

The new regulations concerning staff training created an increased demand for post-secondary Early Childhood courses, and Holland College introduced the first Early Childhood Extension course in September 1986. This was the first time in almost 20 years that part-time study leading to a diploma in Early Childhood Education was available in this province.

The University of Prince Edward Island's Extension Office also responded to the demand for early childhood courses and commenced the provision of courses for those people who needed to supplement related training with courses more specific to Early Childhood Education.

In September 1987, Government adopted *guiding principles for the development of child-care services*. Principles addressed five key areas of quality, affordability, availability, services for children with special needs and parental involvement. At the same time, Government announced the implementation of the Direct Funding Program for licensed child-care facilities. This program included a mix of operating grants for all licensed programs, as well as Infant Incentive Grants for programs with spaces for infants.

In October 1988, the Department of Health and Social Services revised its policy for children with special needs, and transferred funding for individualized programs to the Direct Funding Program in the form of grants to centres. The new program allowed centres to maximize resources and called for an integrated approach to individualized program plans.

Recent Developments

In 2000, Government announced a publicly funded, community-based kindergarten program in PEI that is co-managed by two departments. The Department of Education is responsible for curriculum, program resources and funding for all five year olds; the Department of Health and Social Services is responsible for licensing and monitoring, staff certification and funding for supports for children with special needs.

The Government of Prince Edward Island has continued to support early childhood education and care as a social, economic and political issue. The provincial child-care budget has increased steadily from a total budget in 1981-1982 of $395,100 to a 2002-2003 budget of $4.5 million.

Population

Prince Edward Island's Department of the Provincial Treasury (Economics, Statistics and Federal Fiscal Relations Division) reports estimated population figures for children from birth to six years of age for 2003:

Population Estimates (2003)				
Age of Child	**Kings**	**Queens**	**Prince**	**Total**
0	177	709	498	1,383
1	200	706	485	1,391
2	193	734	477	1,405
3	214	802	500	1,517
4	226	823	523	1,572
5	225	797	495	1,518
6	254	869	530	1,653
Total	**1,490**	**5,441**	**3,508**	**10,439**

Based on 2001 census data, participation rates for women on PEI in the labour force continue to remain high:

Female Labour Force Participation – PEI	
Women with children living at home	78.2%
Women with children under 6 years only	81.8%
Women with children under 6 years and over 6 years	83.4%
Women with children over 6 years only	76.5%

(Source: 2001 Census Table no. 95F0490XCB01002.ivt)

Using rounded estimates, the Child Care Resource and Research Unit at the University of Toronto (Friendly, et. al., 2002) reports the number of children with mothers in the paid labour force for Prince Edward Island:

Children with Mothers in the Paid Labour Force Prince Edward Island 2001 (rounded estimates)	
Age of Child	Number of Children
0-2 years	3,200
3-5 years	3,500
6-12 years	10,100
Total 0-12 years	16,900

Child Care Facilities Act

In Prince Edward Island, the *Child Care Facilities Act* regulates the operation of early childhood education and care programs. The regulations to the *Child Care Facilities Act* provide for licensing, physical facilities, public health, fire emergency and safety, nutrition, administration, staffing and certification. The Child Care Facilities Board is described in the act, and includes multi-disciplinary representation including health, education, parents and early childhood educators. The Child Care Facilities Board is responsible to ensure the provision of child care that is safe, of good quality and appropriate to the needs of children. The board monitors programs, investigates complaints and issues licenses.

Licenses may be issued for Type 1 facilities, including early childhood centres (kindergarten, nursery school and full-day programs for mixed age groups of children); and Type 2 facilities, including day-care homes, school-age child-care centres and occasional centres.

Government monitoring includes a legislated annual visit by designated inspectors. Government also provides funding for MIKE (Measuring and Improving Kids' Environments) which uses the *Early Childhood Environment Rating Scale – Revised* (Harms, T., Clifford, R.M., and Cryer, D. (1998) *Early Childhood Environment Rating Scale – Revised*. New York: Teachers College Press.) This scale is used to measure quality and monitor its improvement. Participation in the MIKE program is voluntary, but over 95 per cent of full-day centres participate.

Child Staff Ratios and Group Size Requirements in Regulated Child-care and Family Child-care Homes		
Age of Child	**Staff : Child Ratio**	**Maximum Group Size**
0-2 years	1 : 3	6
2-3 years	1 : 5	not specified
3-5 years	1 : 10	not specified
5-6 years	1 : 12	not specified
7 years and on	1 : 15	not specified

Staff Training Requirements	
Type 1 Facilities: early childhood centres, including "Kindergarten" and full-day early childhood education and care programs	• Centre supervisors and at least one full time staff must have successfully completed a post-secondary diploma in early childhood education from a minimum of a one-year program; regulations outline other options, including a two-year diploma or a degree in related field. • In order to be certified as an "early childhood supervisor," academic training must be combined with a specified number of years of experience, (e.g., a one-year diploma plus three years of experience; a two-year diploma plus two years of experience). • Thirty hours of in-service training in each three-year period is required for all staff.
Type 2 Facilities: family child-care homes, school-age child-care centres and occasional centres	• Minimum of 30 hours training relevant to the age of the children is required. • Supporting references from at least two community members must be provided.
Each centre or home is required to have at least one staff person present at all times with up-to-date first aid training from a provincially recognized organization.	

Publicly funded, Community-based Kindergarten

Kindergarten is provided through the regulated early childhood education and care system, with approximately 50 per cent of kindergarten programs offered as part of a full-day early childhood program. This provides a "seamless day" in which the child participates in a kindergarten class as a portion of the full-day program. The three-hour kindergarten program is universally available, with no cost to parents. Parents are then responsible for the balance of fees charged by the centre for the remaining portion of the day.

Kindergarten programs may also be provided in half-day programs. Approximately 30 per cent of the half-day programs are situated in available space in elementary schools. Kindergartens operating in a school building must have a parent board and, with a few exceptions, are primarily limited to provision of half-day programs.

The Department of Health and Social Services and the Department of Education share responsibility for kindergarten. The Department of Education provides funding for a half-day core kindergarten program and is responsible for the curriculum and in-service education. "Kindergarten mentors" attached to the Department of Education visit the programs and provide on-site consultation in regard to implementing the province-wide curriculum.

The Department of Health and Social Services is responsible for licensing kindergartens, staff certification, and the provision of funding to support the inclusion of children with special needs. Kindergartens operate under the *Child Care Facilities Act*.

Participation in kindergarten is not compulsory; however, as of 2002-2003, 97 per cent of eligible children attend. Prince Edward Island is changing the age of kindergarten and school entry to ensure that children are six years of age on or before August 31 of the year they enter Grade 1. This change will take place gradually over a six-year period beginning in the 2003-2004 school year. The gradual implementation schedule was chosen to minimize, to the extent possible, the impact this change will have on families and kindergarten/public school systems.

Programs operate between seven to 10 months a year and offer a play-based, core curriculum in Language Arts and Mathematics. In English programs, the curriculum outcomes are adapted from the Atlantic Provinces Education Program, while in French programs, the curriculum is provincially developed.

The core kindergarten program must operate for no less than three hours per day, five days a week or the equivalent, and provide 12 hours of instructional time per week.

Availability and Accessibility

Planning for early childhood education and care programs is considered within the broader context of PEI's Healthy Child Development Strategy. However, while the Children's Secretariat supports communities through the planning process, the actual development and operation of licensed early childhood centres are the responsibility of individual owners/operators and non-profit community organizations.

Number of Full- and Part-time Child-care Spaces by Type 2002-2003			
Centre-based			**Family Child Care**
Type of Space	**Full-time**	**Part-time**	
Infants	60	-	10
Preschool	3,931	67	15
School Age	-	596	10
Total	3,991	663	35

The majority (76 per cent) of regulated full-day early childhood centres are privately owned and operated (2002-2003). The remainder (24 per cent) are operated by non-profit community boards and/or other community-based organizations (e.g., churches).

In order to calculate the availability of spaces for children in PEI, 50 per cent of six-year-old children were included, since the early childhood education and care system includes kindergarten, and therefore some six-year-olds (those born between January and June) would be in the early childhood system. Using a total population figure of 9,611 (children five years age and under, plus 50 per cent of six-year-olds), Prince Edward Island had enough licensed spaces in 2002-2003 for approximately 42.5 per cent of all children from birth to six years of age (inclusive). This includes kindergarten spaces, which are part of the early childhood education and care system.

Of the 4,083 full- and part-time spaces for children from birth to six years of age, only 1.7 per cent (70 spaces) are available for children younger than two years of age. While the shortage of spaces for infants presents challenges for parents who are employed, the availability of spaces for children from two to six years (6,837 children) is considerable, with enough spaces for approximately 59 per cent of all children between these ages.

Affordability

The cost of licensed early childhood education and care programs is one of the most significant barriers to participation for families with young children. Despite the relatively high cost to parents, fees charged in licensed programs do not allow the centres to provide wages and benefits commensurate with the level of education and responsibility of early childhood educators.

Provincial and territorial governments have tried to address this challenge by providing subsidies for low income parents, and operating grants to centres. In Prince Edward Island, the Child Care Subsidy Program was introduced in 1977, and is administered by regional health authorities across the province.

The Child Care Subsidy Program does not charge parents a user fee, but child-care services may charge fees above the program's maximum subsidy rate and require the parent to pay the difference. Once parents are determined to be eligible for subsidy, they may use that subsidy at any licensed centre or family day-care home. Maximum subsidy is determined by the age of the child:

Maximum Daily Subsidy 2002-2003	
Infants (younger than two-years-old)	$24
Two and three-years-old	$20
Three, four, and five-years-old	$19
School-age children	$18

In 2002-2003, the expenditure for the Child Care Subsidy Program totalled $3,256,100.

Eligibility for subsidy is determined by a review of the family's reason for needing child care, as well as consideration of the needs of the child. An income test considers family income and family size in order to determine eligibility for full or partial subsidy.

Child Care Subsidy Program 2002-2003			
Income Eligibility Criteria	**Family Size**	**Turning Point***	**Break-even Point****
	Single parent, one child	$13,440 (net)	$25,440 (net)
	Two parents, two children	$19,200 (net)	$51,040 (net)
User fee/surcharge	There is no user fee, but centres may charge parents the difference between centre fees and maximum subsidy available		
Eligible services	Any licensed centre or family child-care home is eligible; in exceptional cases, subsidy may be available for unlicensed care.		

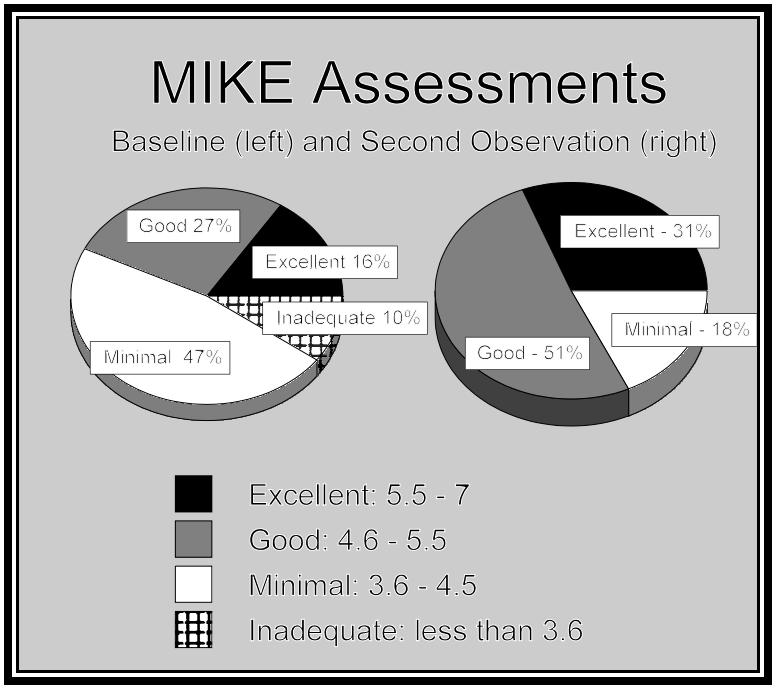
* The turning point is the income level up to which a full subsidy is available.

** Partial subsidy is available up to the break-even point, after which subsidy is no longer available.

Quality

It is generally understood that the benefits to children from participation in early childhood education and care programs is directly related to their participation in programs of high quality. Quality in itself, however, continues to be a topic of study for researchers and policy-makers around the world.

In Prince Edward Island, a concerted effort to improve quality was undertaken with the introduction of the Measuring and Improving Kids' Environments (MIKE) program. The MIKE program is a successful partnership between the PEI Department of Health and Social Services, the Early Childhood Development Association of PEI (ECDA) and licensed full-day early childhood centers across PEI. The program is funded by the Department of Health and Social Services as a component of PEI's Healthy Child Development Strategy.



The On-site Consultation Model involves the use of external program consultants with training in early childhood education and experience in licensed centers, the Early Childhood Environment Rating Scale – Revised (ECERS-R) and the Canadian Supplementary Scale (CSS). The consultation process involves gathering information and resources, conducting training and engaging individuals in an evaluation process. Although the On-site Consultation Model from *Keeping the Door Open* was used to inform and guide the work in the first 10-month cycle of the pilot, the MIKE model evolved with a conscious focus on asset and community-based development strategies. The most important factor in the MIKE consultations is the nature of the relationships that develop and the processes used to support the relationships.

Inclusive

In 1988, Prince Edward Island introduced Special Needs Grants in order to encourage licensed early childhood centres to provide inclusive programs for children who needed additional supports to participate in centre activities and to attain developmental goals. Funding is used to employ additional staff to lower child staff ratios in the centre. Lower child staff ratios are intended to allow all staff to provide extra support to the children who need it.

Funding and requests for special needs funding has consistently increased over time.

Supports for Children With Special Needs			
	2000-2001	**2001-2002**	**2002-2003**
Number of children (full and part-time)	165	164	175
Number of centres	55	56	58
Budget allocation	$580,200	$880,200	$880,200
Budget expenditure*	$779,378	$867,148	$1,060,134

* Includes over-expenditure required to eliminate wait list for special needs supports.

Parental Choice

The Department of Health and Social Services provides resources designed for parents, to support them in making informed decisions regarding the selection of an early childhood program.

The *Parents' Guide to Early Childhood Programs* provides parents with information about subsidies and what to expect, and describes the types of requirements for licensed centres. Parents are urged to visit centres prior to selecting one for their child, and encouraged to discuss centre policies. The guide provides parents with a sample of questions that will help them gain a better understanding of the day-to-day activities in early childhood programs.

The *Directory of Licensed Child Care Programs* provides parents with information on all licensed programs across Prince Edward Island and gives information about child-care subsidies.

Labour Force Issues

In 2001, the Government of Prince Edward Island supported the Early Childhood Development Association of PEI in conducting a survey of wages and working conditions in child-care settings. The Review and Analysis of the Prince Edward Island Early Childhood Education Sector reported median gross hourly wages for centre-based staff (full- and part-time combined):

- Certified staff (at least one year of Early Childhood Education and Care training): $8 per hour
- Uncertified staff: $7.01 per hour
- Staff working with children with special needs: $9 per hour

Other Funding

The Department of Health and Social Services provides operational funding to licensed centres. However, funding is limited to those centres licensed prior to 1992. Approximately 50 per cent of centres and 50 per cent of regulated family child-care homes do not receive operating grants.

Operating Grants	
Full-day centre programs	$0.91/day/space
Part-time centre-based programs (nursery schools, play schools, school-age child-care centres)	12 children or fewer – $682 per year
	up to 24 children – $1,092 per year
	up to 50 children – $1,820 per year
Family child-care homes	$450 per year
Infant incentive grants ($250 per year) are also provided to both centres and homes enrolling at least one child younger than age two on a regular basis for at least six months per year.	

Training and Professional Development

The Departments of Health and Social Services and Education each provide an annual allocation to the Early Childhood Development Association (ECDA) to assist with the purchase of resources and to support professional development activities. In 2002-2003, each department contributed $8,600 to the ECDA, for a total of $17,200.

IV. Indicators of 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."[1]

Provincial, territorial and federal governments across Canada have been working together, and with communities, to improve child well-being for a number of years. Governments have recognized the importance of regularly monitoring and reporting on the status of young children's well-being as a means of helping inform policy-making and building public awareness and understanding. In their September 2000 Communiqué on Early Childhood Development, 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.*"

PEI will report on indicators of child well-being within the categories of:

- Physical Development
- Safety and Security
- Early Development (including social and emotional development)
- Family Related Indicators
- Community Related Indicators

[1] First Ministers' Communiqué on Early Childhood Development, September 2000

1. *Physical Health*

A. Infant Mortality

"The 20th century in Canada has been a time of tremendous progress against infant mortality."[2] Once a common occurrence, infant death is now a relatively rare event. Researchers at Statistics Canada therefore interpret this positive trend as "undisputed progress in efforts to secure the health of Canadian children."[3]

The infant mortality rate is a long-established measure of child health. The most dramatic improvements in infant mortality have taken place over the last three decades. Statistics Canada recently compared our long-term trends in infant mortality rates to countries such as the United States, the United Kingdom, France and Sweden. One key finding reported that, among these nations, Canada recorded the greatest decrease in infant mortality from 1970 to 1995. It is telling that the period of most dramatic improvement occurred from 1970 to 1975, coinciding with the introduction of universal medical care.

For this reason, infant mortality is an indicator closely tied to economic status and social factors. Rates of infant death are intimately tied to the effectiveness of medical care, preventive care and the attention paid to maternal and child health within a formal health care system. The rate also reflects social factors in a baby's environment, such as maternal education, smoking and deprivation – indicators that will be discussed in turn later in this report.

How does Canada rank among nations today?

Among developed countries, an infant mortality rate of less than four per 1,000 live births is considered an exceptionally good record. Six nations had achieved this low rate of infant death in the year 2000: Iceland (3), Japan (3.2), Sweden (3.4), Finland (3.8), Norway, (3.8), Spain (3.9).[4] Among the 30 member states of the Organization of Economic Cooperation and Development(OECD), Canada ranked 14th with an infant mortality rate of 5.3.

Researchers have noted that the decline in infant mortality in Canada had levelled off by the mid-1990s, with the result that various nations pulled ahead of Canada. Thus, while medicare has been able to address long-standing regional differences in infant mortality, income-related disparities in infant mortality remain a challenge. Today, the largest infant mortality gaps in our society are those which exist between wealthy and poor neighbourhoods.[5]

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[2] "Health Status of Children," *Health Reports* (Statistics Canada Catalogue 82-003) 1999; 1(3): 25-34.

[3] *Ibid.*

[4] OECD, "Infant Mortality-Deaths per 1000 Live Births," *OECD Health Data, 2003* (http://www.oecd.int) November 24, 2003. There is no infant mortality data given for Korea or New Zealand for 2000 from this source.

[5] *Health Status of Children*.

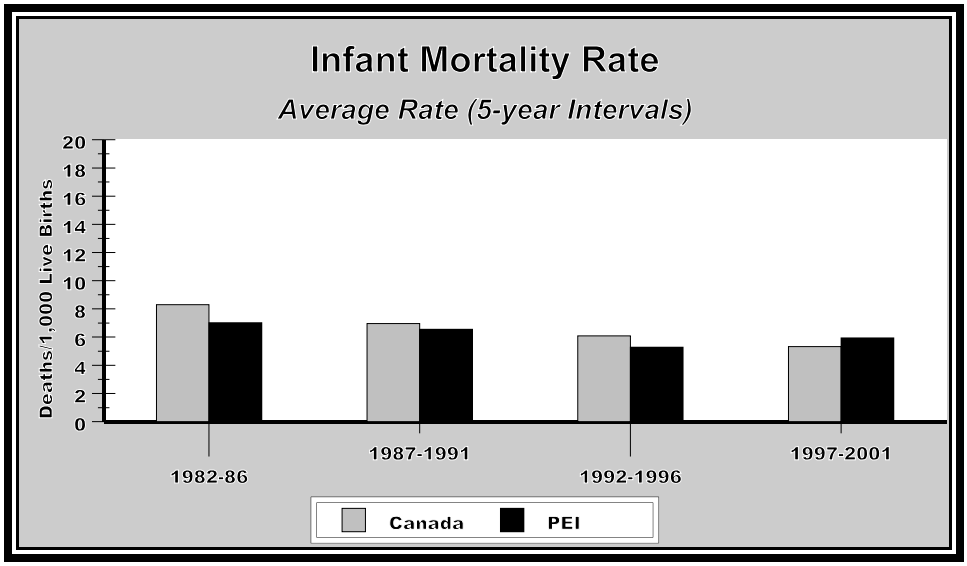
How does Prince Edward Island rank within Canada?

For the year 2001, the year for which we have most recent confirmed data on infant mortality, PEI had a relatively high rate of infant mortality. While the rate for Canada was 5.2 in 2001, the rate for Prince Edward Island was 7.2. Our provincial rate was the highest among provinces in Canada.

Is this high rate of infant mortality a consistent trend?

Prince Edward Island's small sample size means that an increase or decrease of a few cases can appear as large fluctuations from year to year. In 2000, the rate of infant mortality on Prince Edward Island was the lowest among provinces, at 3.2.

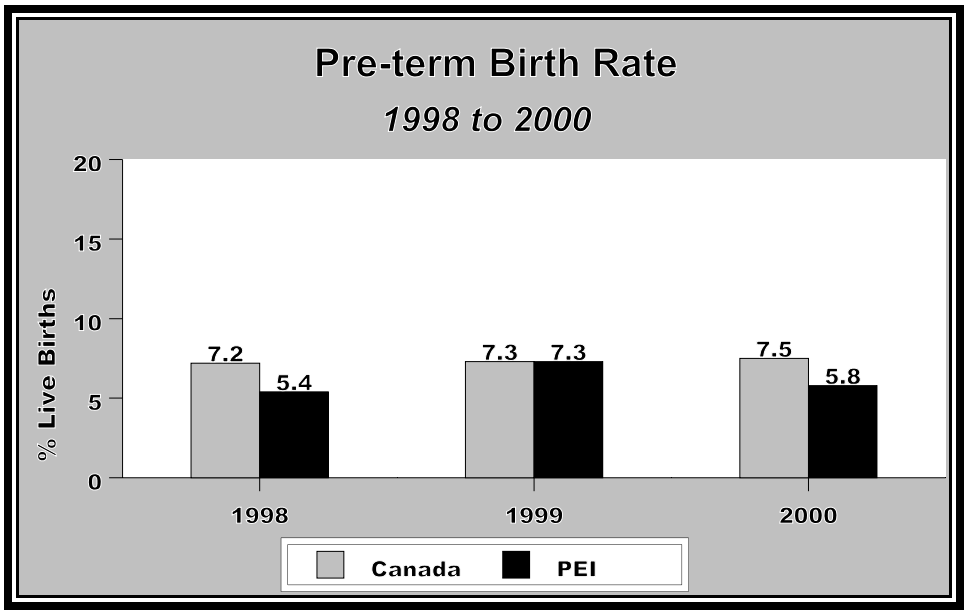
For this reason, presenting average rates over five-year periods is often a better and more accurate representation of trends. The data in the following chart represent five-year average rates in infant mortality over the last two decades from 1982 to 2001.



- Over the past two decades, the infant mortality rates for both PEI and Canada have decreased consistently.
- The infant mortality rate for Prince Edward Island decreased by 15 per cent over the two decades captured above.

B. Pre-term Birth Rate

The pre-term birth rate is the percentage of live births with a gestational age at birth of less than 37 completed weeks (less than 259 days). In Canada, 75 per cent to 85 per cent of all prenatal mortality results from pre-term births. If the child survives, health problems often persist. Pre-term birth can result in respiratory problems, various infections and neurodevelopmental problems for the baby.



Source: Statistics Canada

- The pre-term birth rate for PEI was lower than the Canadian average in 1998 and 2000, and the same as the Canadian average in 1999.

In addition, in the year 2000, PEI had the lowest rate of pre-term births among provinces in Canada. The next lowest rate was reported at 6.7.

C. Healthy Birthweight

Birthweight is also a strong indicator of newborn health, and a key factor affecting infant survival, health and development. It is a reliable measure of a newborn's chances of survival and future health.

i) Low Birthweight

Low birthweight is reported as the percentage of live births where the baby has a weight less than 2,500 grams (just over five pounds). Perinatal and infant mortality are highly correlated with the incidence of low birthweight.[6] Children born too small are at a greater risk of dying during the first year of life; and if they survive, they have a greater risk of disability and diseases such as cerebral palsy, visual problems, learning disabilities and respiratory problems.[7]

Low birthweight is higher among younger and older mothers than among mothers aged 25 to 34. It is also related to prematurity, as close to half of preterm babies weigh less than 2,500 grams, compared with only about two per cent of those born at or after 37 weeks gestation. Parity also affects birthweight; low birthweight is more common among first-born children and those that are the mother's fourth or later birth than children who are second and third in birth order.[8]

Low birthweight is associated with poor maternal health, lifestyle and economic circumstances. Appropriate medical care and a healthy lifestyle for the mother can improve the chances that the baby will have a healthy birthweight. Smoking during pregnancy is the most clearly established "preventable" risk factor of low infant birthweight, contributing to "small for gestational age," premature birth, spontaneous abortion, respiratory distress syndrome and sudden infant death syndrome. Long-term effects include poor cognitive performance and decreased physical growth.

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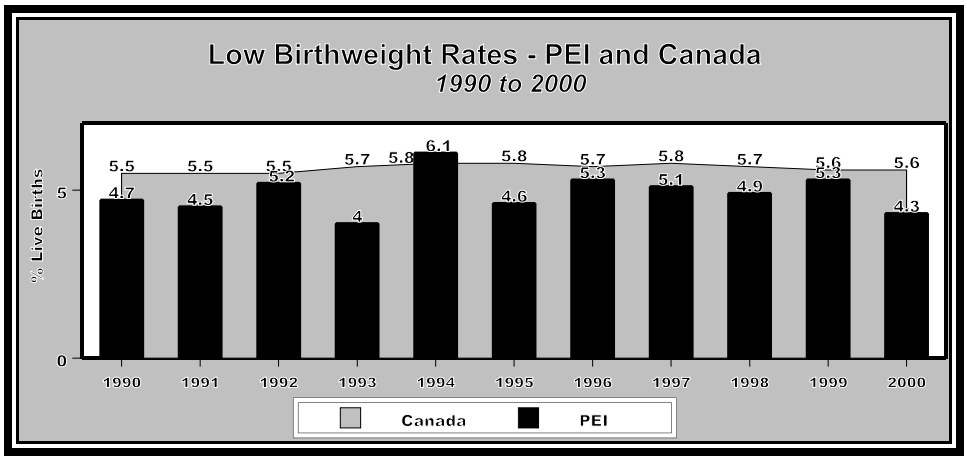
[6] *Ibid.*

[7] Jiajian Chen and Wayne J. Millar, "Birth outcome, the social environment and child health," *Health Reports* (Statistics Canada Catalogue 82-003) 1999, 10(4): 57-67.

[8] François Nault, "Infant Mortality and Low Birthweight, 1975-1995," *Health Reports* (Statistics Canada Catalogue 82-003-XPB) 1997, 3(9): 39-45.

Low birthweight is strongly related to infant mortality. Data collection for this indicator of child well-being has been underway for many years. The chart below gives a 10-year trend in rates of low birthweight from 1990 to 2000. A low rate of low birthweight babies is a good overall sign of newborn health. Among developed nations, rates lower than five per cent are considered good.[9]



- Over the past decade, data for both PEI and Canada showed neither a significant increase nor decrease in the low birthweight rate.

- Prince Edward Island had, on average, a lower rate of low birthweight births than the Canadian average from 1990 to 2000.

- The proportion of low birthweight babies on PEI is considered, by national and international standards, to be "good."

In addition, Prince Edward Island had, among all Canadian provinces, the smallest proportion of low birthweight babies born in the year 2000. Low birthweight data is also presented in the section on maternal smoking, which is explored in the assessment of family-related indicators.

ii) High Birthweight

The high birthweight rate is the percentage of live births where the baby has a weight greater than 4,000 grams (just under nine pounds).

The reasons babies are born with high birthweights vary. Women who have already had more than one pregnancy are more likely to have a baby over 4,000 grams. However, high birthweight is strongly associated with maternal obesity and, to a lesser extent, with

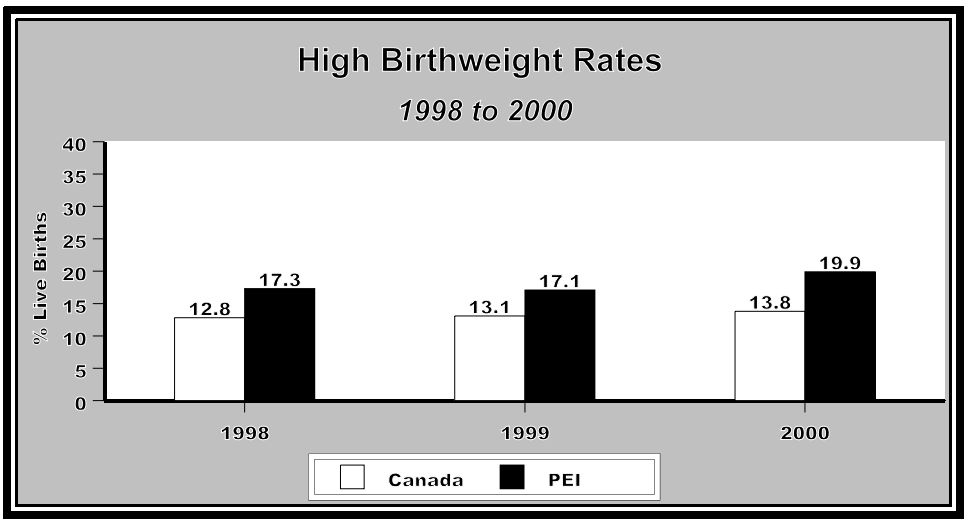
[9] OECD, *OECD Health Data, 2001* (CD-ROM).

gestational diabetes. Gestational diabetes carries significant health risks for mother and infant and increases the risk for the mother of developing non-insulin-dependent diabetes at a later date. Babies born of diabetic mothers are at greater risk for the future development of hypoglycemia.

With high birthweight babies, there is a greater potential for complications for both mother and baby during delivery. For the mother, longer labour and higher risk of trauma to the birth canal are potential consequences. Increased incidence of cesarean sections, which are accompanied by another set of risk factors, have also been associated with high birthweight. For the baby, there is a greater risk of asphyxia, depressed skull fractures, bruising and other cranial trauma. Injuries resulting from difficult shoulder deliveries include fractures of the infant's collar bone and possibly paralysis of the shoulder and face due to nerve damage.

High birthweight babies also tend to have poor motor skills and more difficulty regulating behavioural states. They tend to be more difficult to arouse, have feeding difficulties and may have problems maintaining a quiet alert state.

Data collection on high birthweights is an initiative of recent years. The following chart gives the national and provincial data for three years, 1998 to 2000.



- In contrast to the low birthweight data, Prince Edward Island had a higher rate of high birthweight births compared to the national average from 1998 to 2000.

In addition, for the year 2000, Prince Edward Island had the largest proportion of high birthweight births among Canadian provinces.

D. Immunization

In Prince Edward Island, childhood immunization, including all innoculations and vaccinations, are administered by Public Health nurses. Generally, children are immunized against common childhood diseases and receive vaccines by needle at two, four, six, 12, 15 and 18 months of age. An additional immunization occurs at or around the age of four years.

The rate of childhood immunization is normally measured by the incidence (meaning the rate of new cases per year) of three childhood diseases. These are invasive meningococcal disease, measles and haemophilus influenza b (Hib). All three are preventable through adequate immunization programs.

i) Incidence of Meningococcal Disease

Children as young as two months of age may now be immunized against this disease, thanks to new and very effective vaccines. The National Advisory Committee on Immunization (NACI) recommends three doses of this new vaccine at two, four and six months of age in order to ensure routine levels of immunization. Most cases of this disease occur in the zero to 19 age group, and immunization programs generally focus on this group. There is strong potential for significant reduction in the incidence of this disease if these protocols are observed.

Like most other jurisdictions in Canada, Prince Edward Island does not presently provide this immunization per the NACI recommendations. Prince Edward Island does provide it, however, for individuals at increased risk of infection due to a splenectomy or equivalent immune deficiency.

ii) Incidence of Measles

All provinces and territories have adopted the goal set by the Pan-American Health Organization to eliminate measles in their population. Two doses of measles vaccine are required for complete protection; the first dose is given at 12 months and the second dose prior to school entry, at either 18 months or four to six years of age. PEI instituted an immunization program including the second dose for measles in 1997.

iii) Haemophilus Influenza-b (invasive) (Hib) Disease

Invasive Hib was the most common cause of bacterial meningitis and a leading cause of other serious invasive infections in children prior to the introduction of Hib vaccines. Vaccine preventable cases are now rare. Four doses of the vaccine are given in combination with diphtheria, pertussis, tetanus and polio before children reach their second birthday. PEI started the four-dose schedule for this vaccine in 1992.

The following table gives the incidence rate for measles, invasive meningococcal disease and invasive Hib disease. The rate is calculated as incidence per 100,000 children aged five years of age or younger.

Incidence Rate for Preventible Childhood Diseases 1998 to 2001					
		1998	**1999**	**2000**	**2001**
Measles	Canada	0.3	0.5	3.7	0.3
	PEI	0	0	0	0
Invasive meningococcal disease	Canada	0.4	0.5	0.7	1.3
	PEI	0	0	0	0
Invasive Hib disease	Canada	0.8	0.8	0.4	0.9
	PEI	0	0	0	0
Source: Division of Immunization and Respiratory Diseases, Health Canada					

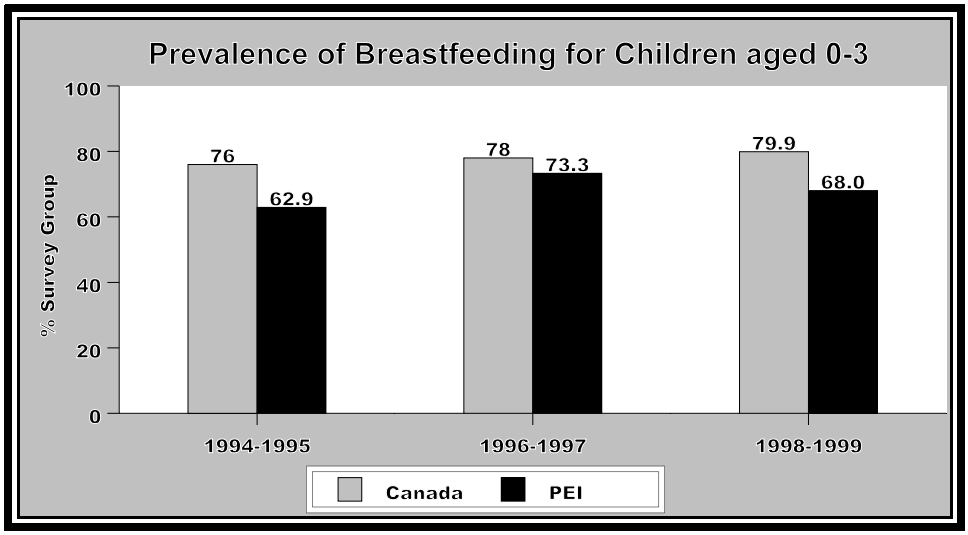
- PEI had no cases of measles, invasive meningococcal disease or Hib disease from 1998 to 2001.

In addition, Prince Edward Island reported only four cases of invasive Hib in the entire population from 1999 to the present.

E. Breastfeeding

Breastfeeding is an ideal source of nutrition for babies. Breast milk contains immunoglobulins and antibodies that fight infection and as a result, breastfed babies have fewer childhood illnesses, including gastrointestinal and respiratory infections, asthma, eczema and food allergies. Breast milk protects babies from other diseases such as *otitis media*, or middle ear infection. Some research shows that breastfed children score higher on tests that measure cognitive development.

Prevalence of breastfeeding reports the proportion of children three years of age or younger who are currently or have ever been breastfed.



Source: NLSCY, Cycles 1 (1994-1995), 2 (1996-1997 and 3 (1998-1999); data from cycle 4 (2000-2001) is not yet available.

- The prevalence of breastfeeding reported among mothers surveyed in PEI was lower than the Canadian average for all three cycles.

In addition, for 1998-1999, PEI reported the third lowest rate of breastfeeding of all provinces and territories.

However, while PEI numbers are relatively low compared to the Canadian average and most other provinces in Canada, a 10-year trend for the rate of mothers who are breastfeeding at the time of hospital discharge does indicate a steady increase of approximately two per cent per year. This data is being collected by the PEI Reproductive Care Program and should be available for the next reporting cycle.

2. Safety and Security

Over the past three decades the major "external" causes of child mortality have been as a result of injury. From 1971 to 1996, researchers at Statistics Canada have charted a significant decline in the rate of these injuries which result in death. This attests to the success of a host of regulatory policy, educational and product safety improvements implemented during this period. For example, it is likely that the reduction in child deaths in motor vehicle crashes is related to changes in the design and use of seatbelts, infant seats and other safety features. Alongside a wide variety of social improvements – better vehicle safety, bicycle helmet use, school bussing, better emergency treatments for trauma as well as the strict enforcement of laws against speeding and drunk driving – there is a marked decline in the number of child deaths due to motor vehicle injuries. The mortality rate for child pedestrians hit by motor vehicles fell by almost 90 per cent between 1971 and 1996.[10]

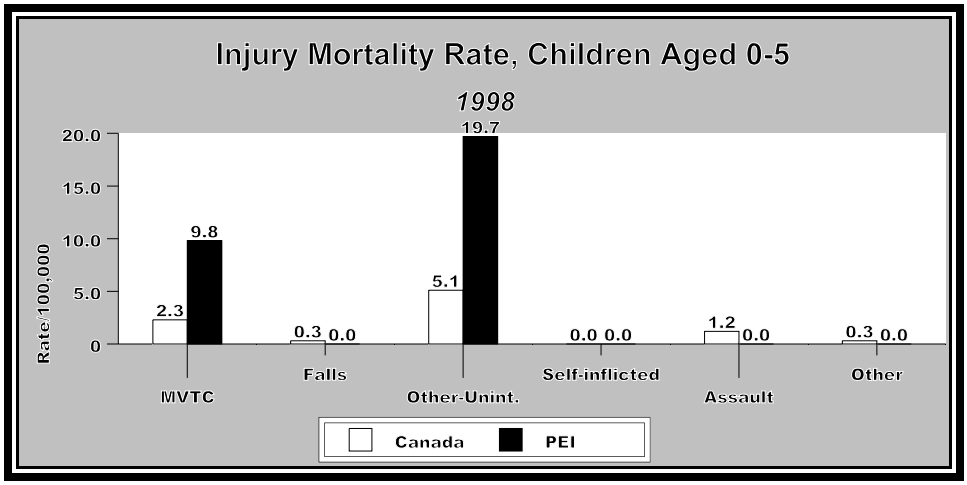
The National Longitudinal Survey on Children and Youth (NLSCY) continues to chart the injury rates for children from birth to five years of age, paying attention to whether the injury results in death or hospitalization. These rates are reported here as indicators of child safety and security.

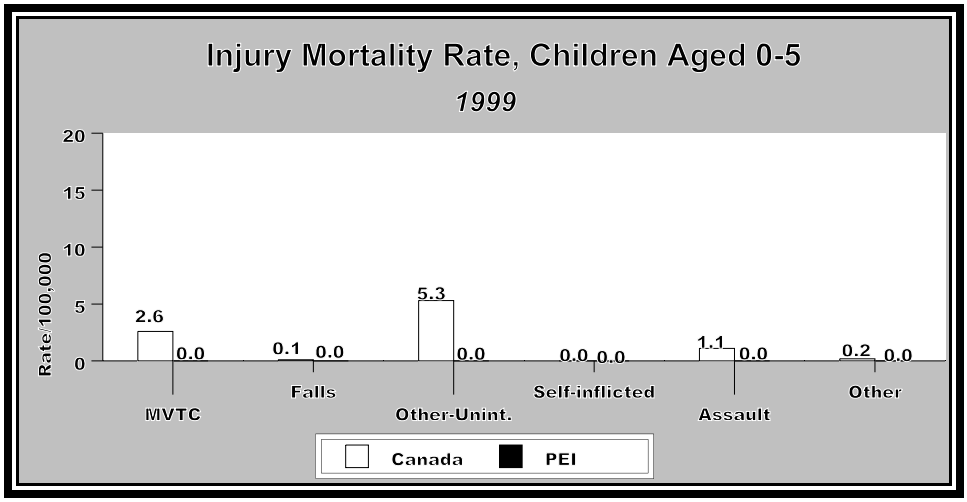
In 1998-1999, the NLSCY reported on six types of injury: motor vehicle traffic crash (MVTC), falls, other unintentional injury, self-inflicted injury, assault and other injury not included in these categories. In 2000, the NLSCY divided childhood injury into the following categories: MVTC, falls, drowning, injury by fire/flame, suffocation and assault, as well as a category for "other" injuries from different causes.

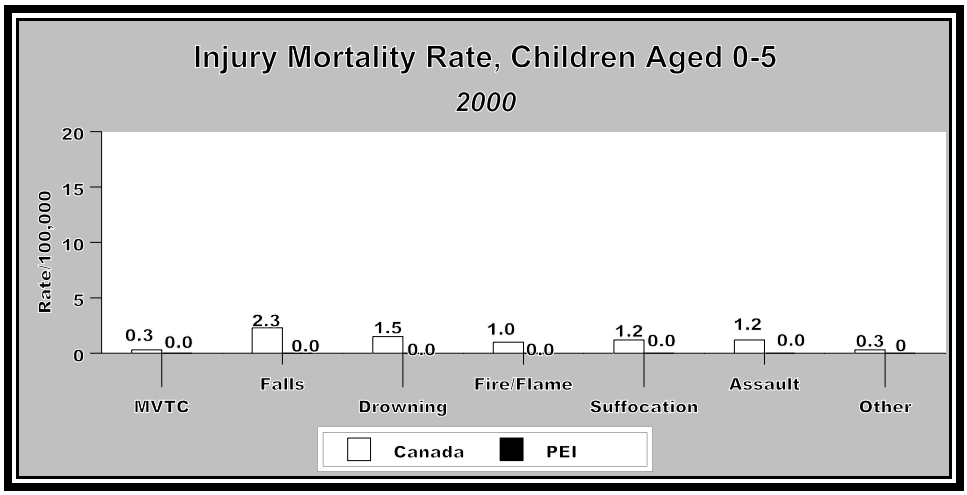
[10] *Health Status of Children.*

A. Injury Mortality Rate

Injury mortality rate is the proportion of children from birth to five years of age who die as a result of an injury. The charts below show the reporting cycles for 1998, 1999 and 2000.







As the charts indicate:

- The injury mortality rates for Prince Edward Island children have been very low in recent years.

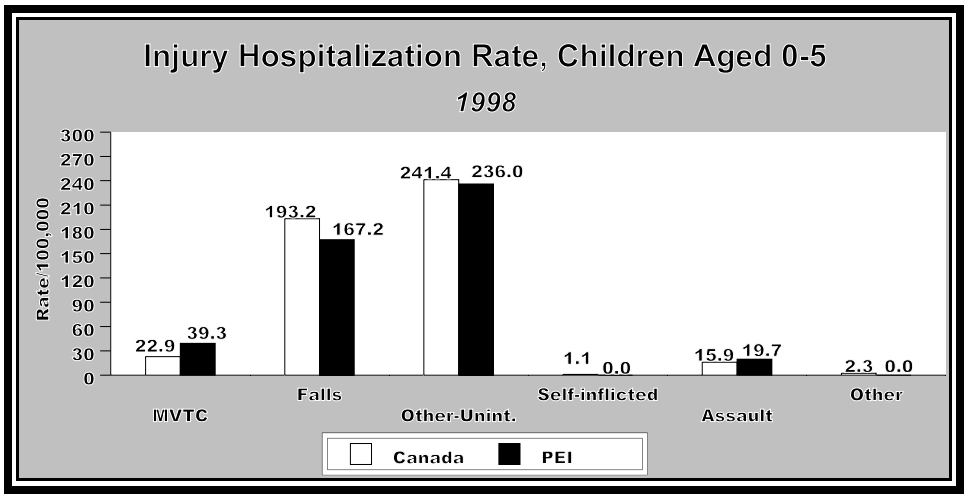
- An exception is seen in the chart for 1998, where the motor vehicle traffic crashes (MVTC) and other unintentional injuries are well above the national rate.

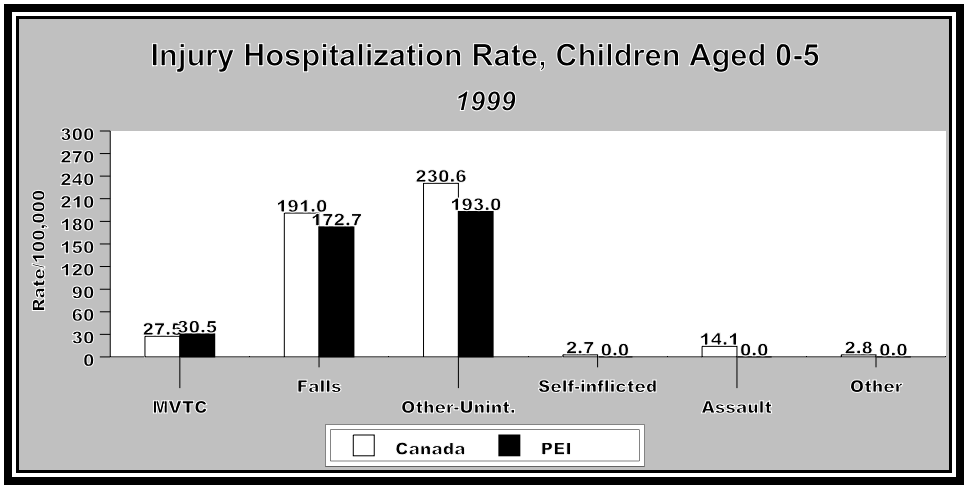
However, when interpreting these results, it is important to note that the small sample size on PEI means minor changes in data from year to year can cause large fluctuations in the rates.

For instance, the 1998 MVTC rate of 9.8 per 100,000 is the result of one death and the 19.7 rate for other unintentional is a result of two deaths.

B. Injury Hospitalization Rate

The two charts below report the rate of children from birth to five years of age hospitalized because of injury for 1998 and 1999.

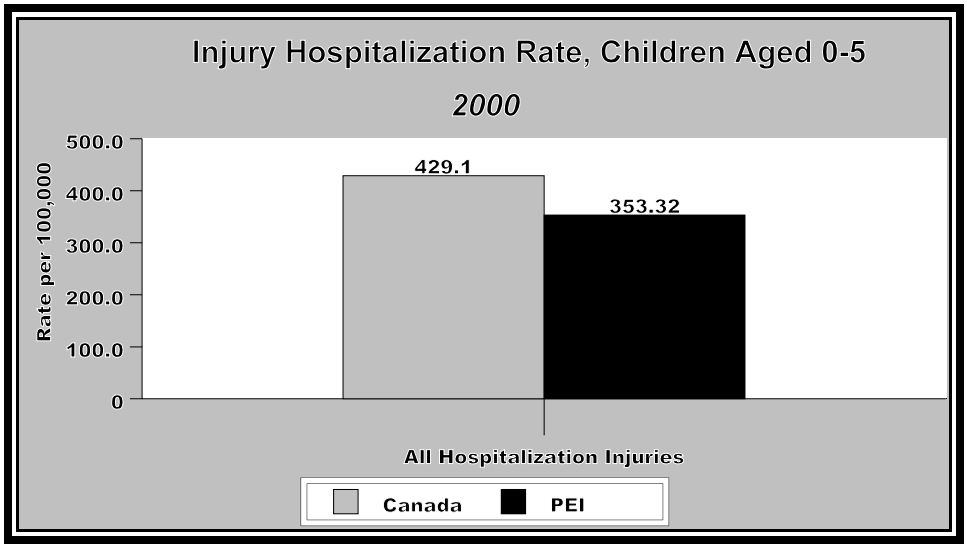




- The injury hospitalization rates in Prince Edward Island tended to be similar to the national rates, with relatively little variation from 1998 to 1999.

- Falls and other unintentional injuries are the most common causes of hospitalization for young children in Canada and in PEI.

The following chart reports the year 2000 injury hospitalization rate for children from birth to five years of age. The data from the NLSCY for 2000 is not broken down by cause of hospitalization. The rate is given per 100,000 population.



- The rate of hospitalization due to injury in PEI was lower than the Canadian average for 2000.

In addition, the rate of injury hospitalization reported for Island children was lowest among provinces and territories in 2000.

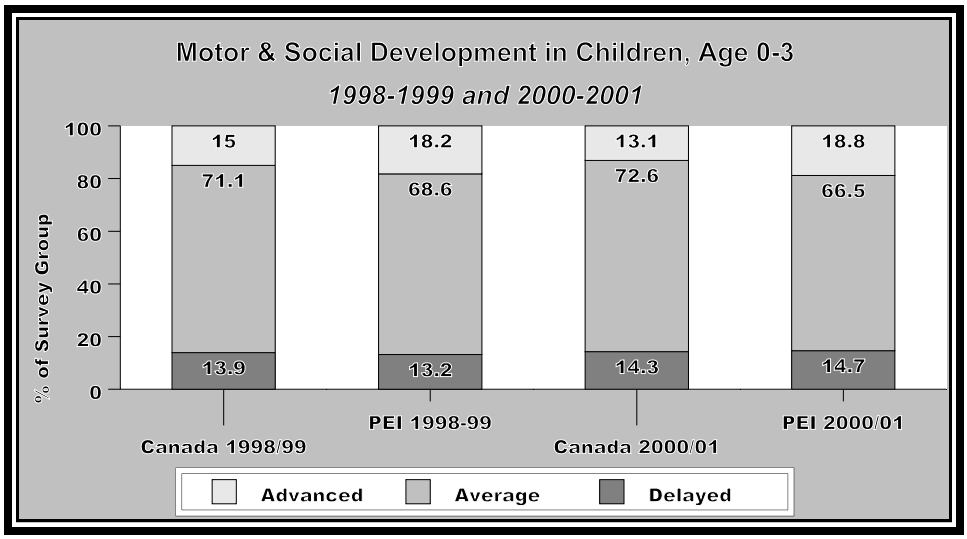
3. *Early Development*

A. Physical Health and Motor Development[11]

i) Motor and Social Development

In the NLSCY, the Motor and Social Development scale consists of a set of 15 questions that measure dimensions of the motor, social and cognitive development of young children from birth through three years; the questions vary by child's age. These questions are asked of the Person Most Knowledgeable (PMK) about the child, who is usually the parent or legal guardian. The questions which focused on motor skills sought answers including whether the infant could follow the movement of an object with his/her eyes, or could sit up by himself or herself. To assess social development, the researcher would ask the PMK if an infant smiled at someone when that person talked to or smiled at her or him. For a child closer to three years of age, a typical question asked was, "Has he/she ever dressed him/herself without any help except for tying shoes?"

Motor and social development from the NLSCY is reported in the chart below as a percentage of children from birth to three years of age who have delayed, average or advanced levels of development in these areas.



[11] Readers comparing this data with the reporting from previous years will note that the data recorded as valid percentages from previous reporting cycles have changed. The NLSCY recalculated statistical "weights," which are assigned to provinces based on the changing populations of children as well as the changing number of children involved in this study. In addition to this, the NLSCY has calculated new scores for the Motor and Social Development section of the Child Questionnaire. The methodology is standardized among all reporting cycles, but the reported data in this section may be slightly different from what was reported in previous years.

- The vast majority of Island children in this age group had an average level of motor and social development in both survey cycles.

- A similar proportion of Island children from birth to three years of age had an advanced level of motor and social development compared to the Canadian average.

- 13.2 per cent were rated as "delayed" in 1998-1099 and 14.7 per cent in 2000-2001, which is similar to the average rate for all children across Canada.

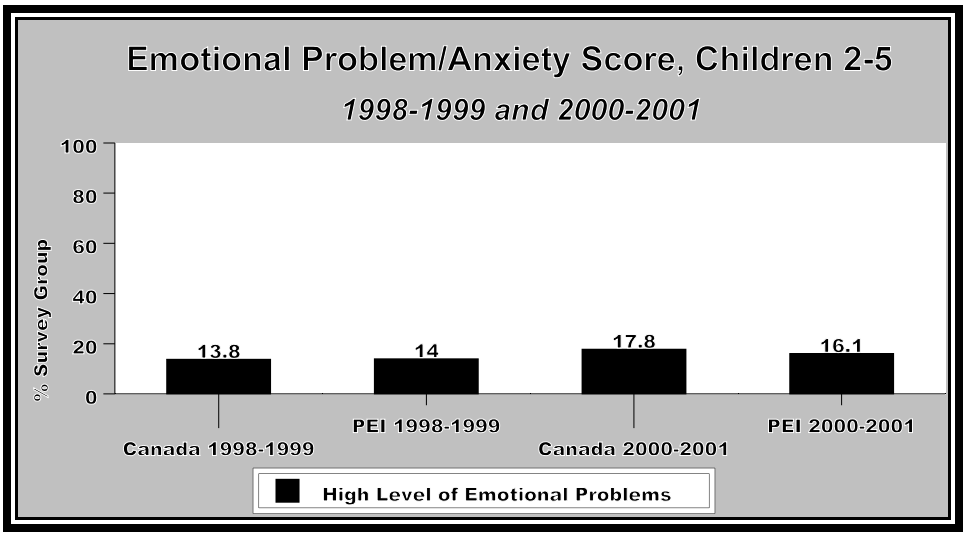
B. Emotional Health

Emotional health indicators provide information on the rates of children aged two to five years who exhibit anxiety or hyperactivity or physical aggression. Once again, the NLSCY survey directed several questions to the PMK.

i) Emotional Problems/Anxiety

The NLSCY captured information about children with Emotional Problems/Anxiety by using a behaviour scale. The purpose of the behaviour scales is to assess the extent of the presence/absence of certain behaviour patterns and characeristics. For example, researchers asked the PMK how often the child seemed to be unhappy or seemed depressed. They were also asked how often the child appeared worried, too fearful, nervous or had trouble enjoying him/herself. The questions associated with the behaviour scales are asked of the PMK and, like many of the findings in this indicator category, do not represent professionally diagnosed problem behaviours.

Emotional problems and/or anxiety measures from the NLSCY are reported as a percentage of children between two and five years of age who have "high" or satisfactory levels of emotional problems and/or anxiety.[12]



Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001).

[12] Satisfactory levels are reported in the data by the term "not high".

- 16.1 per cent of Island children between the ages of two and five exhibited high levels of emotional problems and/or anxiety, which is similar to the Canadian average of 17.8 per cent.

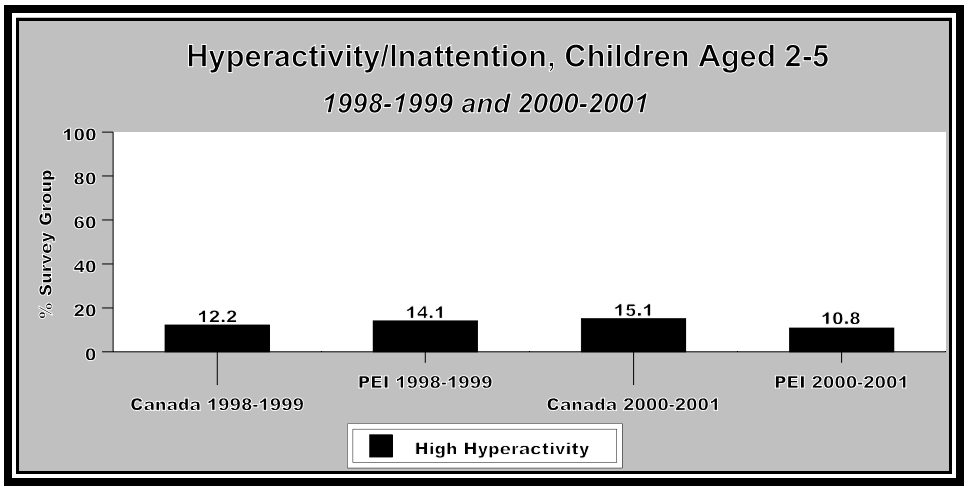
- The rate of children reported in 2000-2001 with high emotional problems had increased since the 1998-1999 cycle for both PEI and Canada.

Note: The rate of high emotional problems in Prince Edward Island children between the ages of two and five was the third lowest among Canadian provinces. The lowest rate reported among provinces was 13.8 per cent.

ii) Hyperactivity/Inattention

The NLSCY also uses behaviour scales to assess the rate of hyperactivity/inattention among children. Once again, the purpose of the behaviour scales is to assess the extent of the presence/absence of certain aspects of a child's behaviour. For example, researchers asked the PMK how often the child was restless, easily distracted, impulsive or could not concentrate, sit still or stick to any activity. As with the previous indicator, the questions associated with the behaviour scales are asked of the PMK and do not represent professionally diagnosed problem behaviours.

The indicator is reported here as a percentage of children two to five years of age who have "high" or "not high" levels of hyperactivity and/or inattention.



- 10.8 per cent of Island children aged two to five years exhibited high levels of hyperactivity and/or inattention.

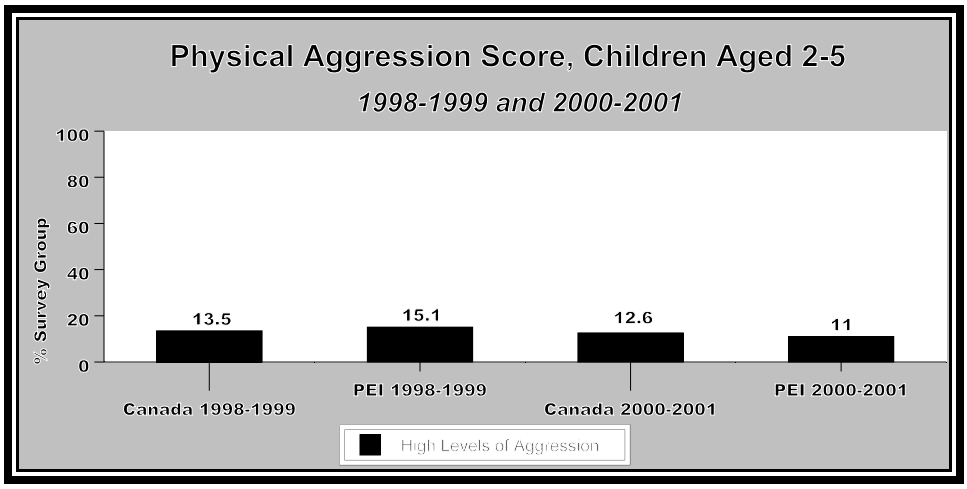
- The 2000-2001 rate for PEI was lower than the Canadian average of 15.1 per cent, and the rate had dropped by 3.3 per cent since 1998-1999.

In addition, for 2000-2001, the young children from the PEI sample had the lowest rate of hyperactivity/inattention among Canadian provinces.

iii) Physical Aggression/Conduct Disorder

Physical aggression and conduct disorder is one of a number of behaviour scales examined in the NLSCY. The purpose of the behaviour scales is to assess the extent of the presence/absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK and do not represent professionally diagnosed problem behaviours. For example, the PMK was asked how often the child is defiant, has difficulty awaiting turn in games, has angry moods, kicks, bites or hits other children. The PMK then indicated whether the child responded to discipline and changed such negative behaviours.

Physical aggression/conduct disorders are reported here as a percentage of children between the ages of two and five years who exhibited high levels of physical aggression, opposition and/or conduct disorder.



- 11 per cent of Island children between the ages of two and five years exhibited high levels of physical aggression, opposition and/or conduct disorder.

- This rate is similar to the Canadian average of 12.6 per cent.

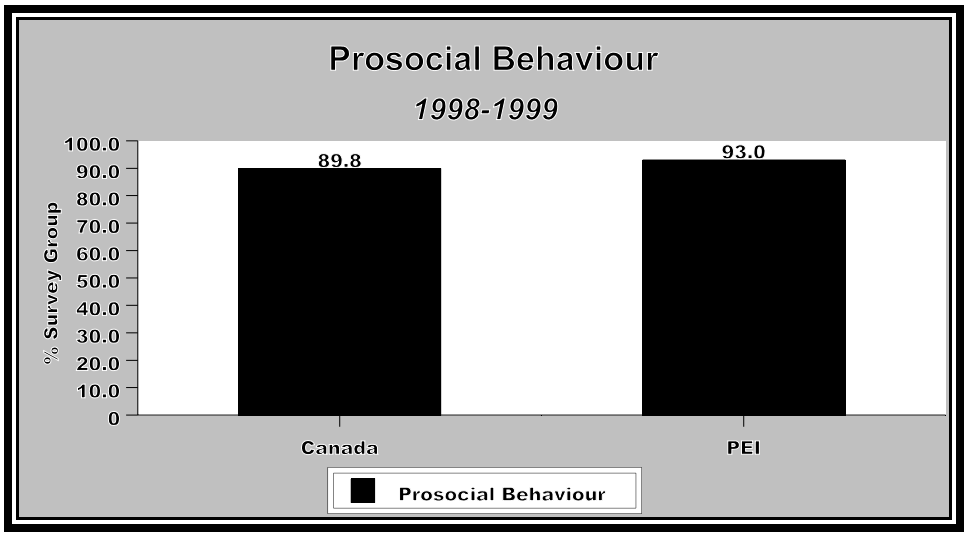
C. Social Knowledge and Competence

Social knowledge and competence indicators provide information on the rates of children between the ages of two to five years who exhibit what NLSCY researchers termed "prosocial behaviour" in previous reporting cycles. Data was collected through the NLSCY, cycle 4 (2000-2001) by surveying the PMK. In the 2000-2001 data, the term "prosocial behaviour" was replaced by an assessment of "personal-social behaviour."

i) Personal-social Behaviour

Personal-social behaviour is examined in the Ages and Stages questionnaire, a new tool used by the NLSCY in 2000-2001. As with all assessments of emotional health, the questions associated with the behaviour scales are asked of the PMK and do not represent professionally diagnosed problem behaviours. They are designed to examine age-appropriate personal-social behaviours, such as how cooperatively a child behaves, how concerned a child is with the welfare of others and the degree to which a child behaves in a positive manner when they are in peer groups. To capture this information from the children surveyed, researchers would ask the PMK how often the child will help another child who is hurt, sick, having difficulty with a task, or comfort a child who is crying/upset.

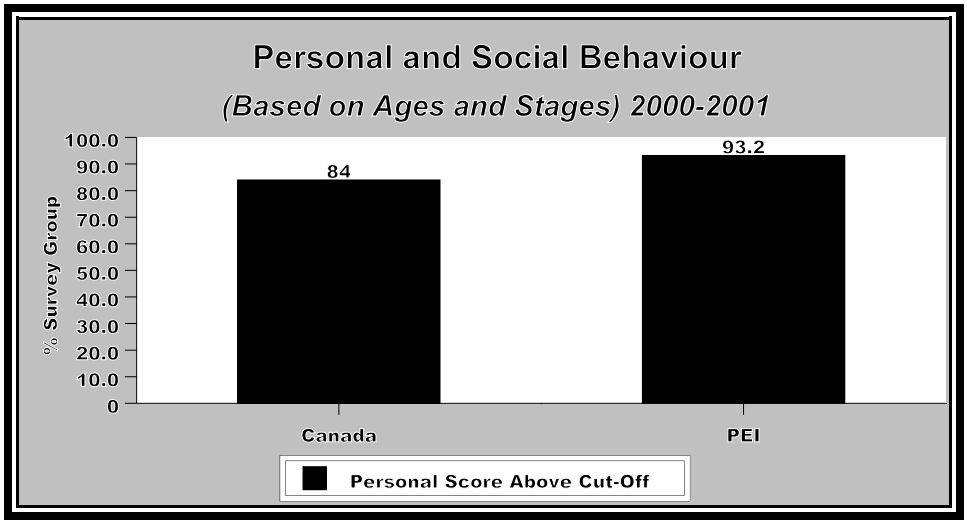
In the 1998-1999, the NLSCY established a score for prosocial behaviour. The survey assessed the behaviour of children aged two to five years.



- In this reporting period, 93 per cent of Island children aged two to five years exhibited satisfactory levels of prosocial behaviour.

- This rate was similar to the Canadian average of 89.9 per cent, and similar to rates reported in other provinces.

For the 2000-2001 data, NLSCY researchers reorganized the way the data would be collected and calculated. For this cycle, they utilized a tool called Ages and Stages. This tool established thresholds (or cut-off points) at which a child's personal and social behaviour may be categorized as "low" and of reportable concern. The following chart gives a percentage of the survey group that scored above this threshold.



- Once again, a large majority of young children on PEI achieved a satisfactory score on personal and social behaviour, above the cut-off established by Ages and Stages.

- The 2000-2001 survey of personal and social behaviour among PEI children indicates a higher rate of positive social and personal behaviour at 93.2 per cent compared to the national average of 84 per cent.

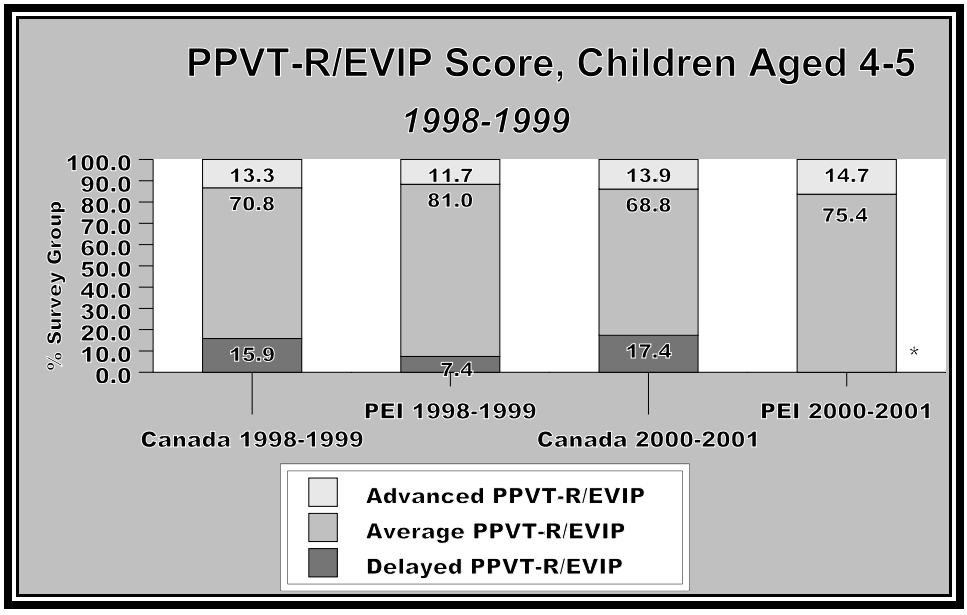
In addition, the percentage of Prince Edward Island children demonstrating positive personal and social behaviour measured here is the highest rate in Canada for 2000-2001.

D. Language Skills

Cognitive learning and communication indicators provide information on receptive and hearing vocabulary skills for children ages four and five years. Data was collected through the NLSCY, cycle three (1998-1999) and cycle four (2000-2001) by directly assessing children using the Peabody Picture and Vocabulary Test – Revised (PPVT-R). The purpose of this test was to measure the degree to which the child was "school-ready."

The Peabody Picture Vocabulary Test – Revised (PPVT-R) measures a child's receptive vocabulary ability. For francophone children, a version using Canadian French is utilized, the *Échelle de vocabulaire en images Peabody* (EVIP). This test measures one facet of general intelligence – vocabulary. During this test, the examiner states a word and the child is shown a page with four line drawings. The examiner asks the child to point to the picture that matches the word.

Language skills measures from the NLSCY are reported as a percentage of children aged four to five years who had delayed, average and advanced receptive or hearing vocabulary skills as per their score on the (PPVT-R/EVIP).



Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001).
* This bar does not represent the total number of children sampled in PEI. The percentage of PEI children with a delayed PPVT-R is too small to calculate what statisticians call a "valid per cent" and the data is not given. See bullet three below.

- When tested in 2000-2001, the vast majority of Island children from the age group sample had average receptive or hearing vocabulary skills.

- In 2000-2001, 14.7 per cent of children from the PEI sample displayed advanced skills, which is similar to the Canadian average of 13.9 per cent, and higher than the rate of advanced skills in 1998-1999.

- Although the small sample size precluded formal publication of the percentage of PEI children with delayed skills in 2000-2001, a rough percentage might be calculated as somewhere in the environs of 10 per cent. Although this must be interpreted with caution, the rough percentage suggests a lower rate than the Canadian average of 17.4 per cent.

4. *Family-related Indicators*

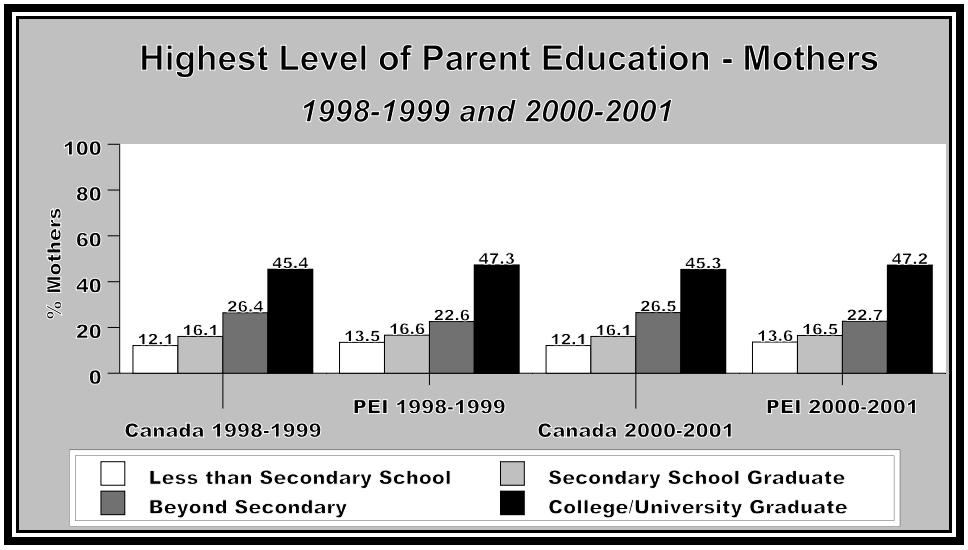
Family-related indicators refer to those measures which reflect various aspects of parental health and behaviour. The health and behaviour of parents or guardians can exert a tremendous influence on the child's own health and well-being. This NLSCY measure looks at family-related indicators to assess the degree to which a child's environment contributed to her or his developing health. There are seven family-related indicators reported here: parental education, level of income, parental depression, tobacco use during pregnancy, family functioning, positive parenting and reading by adult. All of the data for the measures reported, except level of income, was gathered through the NLSCY survey.

A. Parental Education

The education level of parents is a particularly important aspect of socio-economic status, and hence child health. Children of parents who did not graduate from high school have almost three times the odds (2.75) of poorer perceived health than children of parents with a university diploma. And among children who experienced perceived health changes, children of parents who did not graduate from high school had greater odds of perceiving a decline in health than children of parents with university-level education.[13]

i) Mother's Level of Education

Mother's highest level of education is defined and reported in the chart below as the highest level of education attained by the mother of children from birth to five years of age.



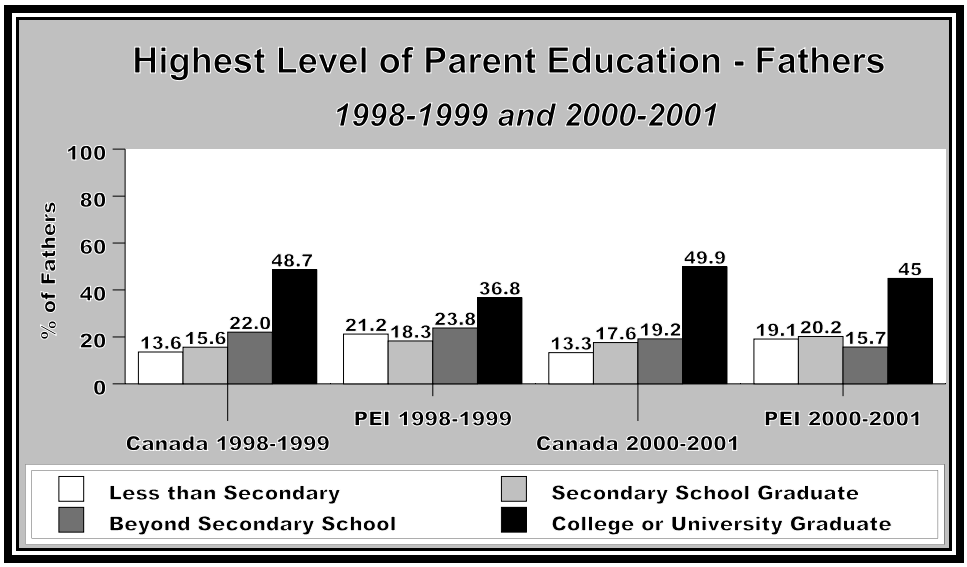
Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001).

[13] *Health Status of Children*,32.

- The rates for different levels of education among mothers surveyed from Prince Edward Island was similar to average rates reported for Canada as a whole for both cycles.

ii) Father's Level of Education

Father's highest level of education is defined as the highest level of education attained by the father of children from birth to five years of age.



Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001).

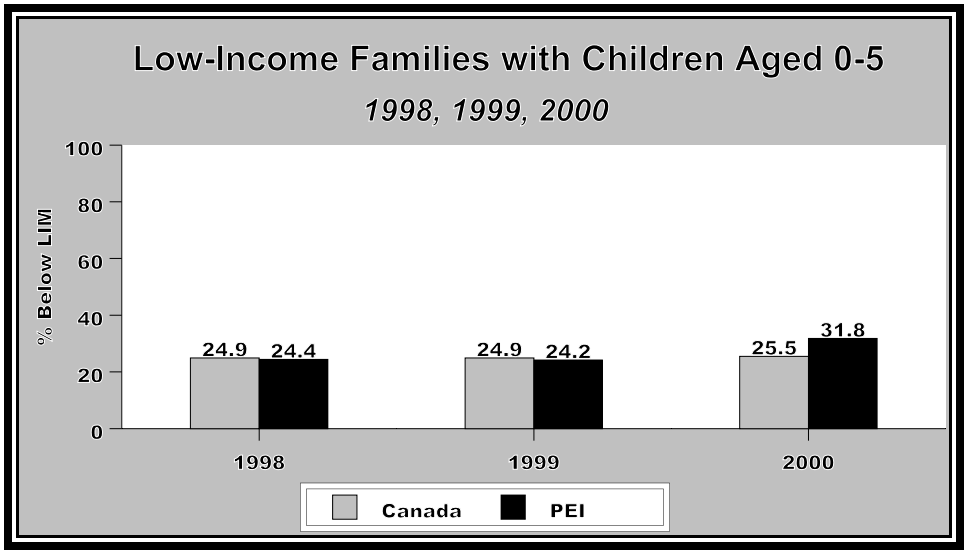
- The education level for fathers on PEI more closely resembled the Canadian averages in 2000-2001 as compared to the data from 1998-1999.

- Although the rate has improved since the 1998-1999 cycle, PEI still shows a lower rate of Island fathers having completed high school than for all of Canada, and as compared to Island mothers.

- Although the number has improved since the 1998-1999 cycle, PEI still shows a lower rate of Island fathers having graduated from college or university when compared to the Canadian average, and when compared to the average for Island mothers.

B. Level of Income

Level of income is a socio-economic factor which NLSCY researchers have determined contributes to a child's health. As part of this research to assess socio-economic status, the NLSCY uses the Post-tax Low-income Measure (LIM). The LIM is a relative measure based on and calculated from median after-tax incomes in Canada. The LIM is equal to half or less of the median after-tax income (the total income after tax at which half of families fall above and half of families fall below) adjusted for family size (number of adults and children). This indicator reflects the proportion of children from birth to five years of age living below the post-tax LIM.



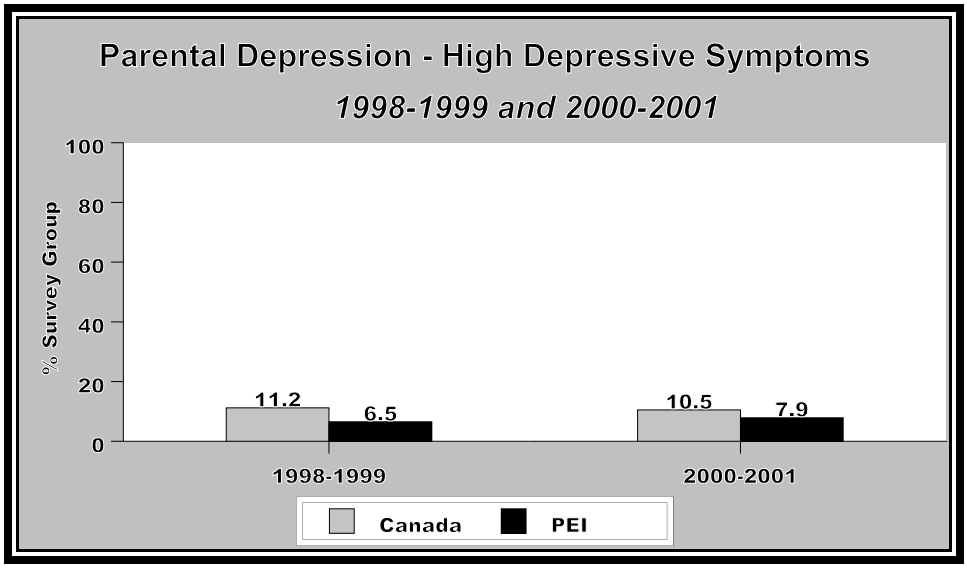
- For 1998, 1999 and 2000, approximately one-quarter of Island children from birth to five years of age were living below the low-income measure.

- These rates are similar to the Canadian average.

Note: The LIM does not reflect geographic differences in living costs across Canada.

C. Parental Health – Depression

Parental depression data is gathered through a parental survey. The depression scale in the NLSCY represents a condensed version of the Statistics Canada Depression Rating Scale (CES-D). This scale measures the occurrence and severity of symptoms associated with depression among surveyed parents/guardians of young children and does not represent the occurrence of *clinically diagnosed* depression. In order to gauge these behaviours, researchers asked a wide variety of questions, such as how often respondents felt "blue" or if they felt hopeful about the future. Other questions measured depressive symptoms in a less obvious manner, posing questions about appetite, whether they had trouble focussing on activities and if it seemed like "everything [they] did was an effort." The chart below shows the rate of children from birth to five years of age whose PMK exhibited high symptoms of depression.



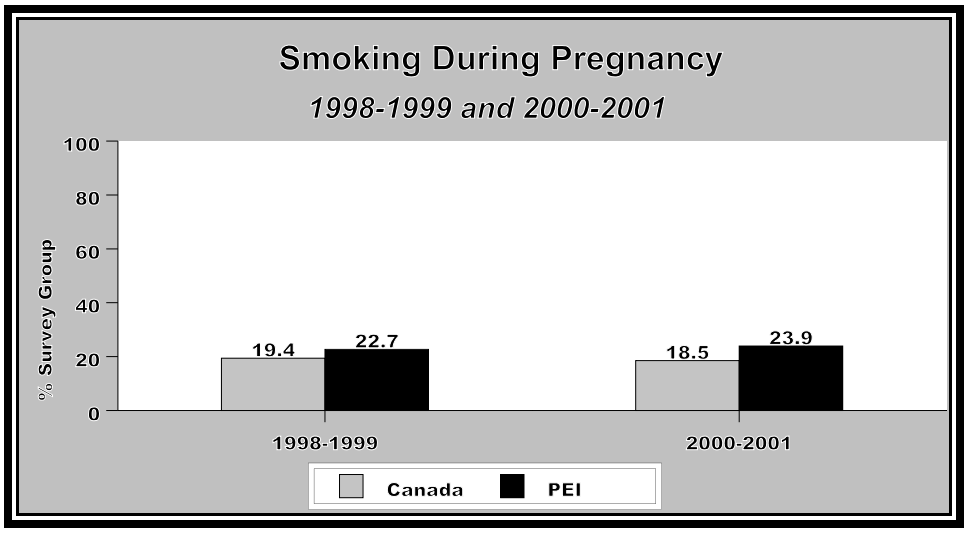
Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001).

- These results indicate that, for both reporting cycles, a very low rate of Island children from birth to five years of age lived with a parent or guardian who reported a high level of depression-like behaviours.

D. Parental Health – Tobacco Use During Pregnancy

Smoking during pregnancy data was collected through the NLSCY which collected information from mothers who had given birth during the previous year.

The chart below reflects the proportion of children aged one year or younger whose mother smoked during her pregnancy with the child, during two reporting cycles.



- Both the 1998-1999 and 2000-2001 reporting cycles found that about one in four Island children aged one year or younger were born to mothers who smoked during pregnancy.

- This rate for PEI was higher than the Canadian average reported in both cycles.

Since 1992-1993, the PEI Reproductive Care Program has assessed the rate of women who smoked around the time of the birth of their children. Data from 1997 to the year 2000 has captured smoking habits of the great majority of pregnant mothers on Prince Edward Island for those years. Since smoking is related to low birthweight, the findings of this initiative are presented as part of this report on child wellness. They are presented below as the percentage of new mothers in each age group who smoked regularly around the time of delivery.

Maternal Smoking at Delivery by Age Group				
Age Group	**1997**	**1998**	**1999**	**2000**
<20 years	47.2%	51.4%	58%	44.9%
20-24	37.5%	42%	37.6%	43.2%
25-29	22.4%	24.2%	21.1%	21.6%
30-34	19.6%	19.2%	13%	13.5%
35 +	17.7%	21.3%	21.9%	17.7%

- Almost half of teenage mothers who delivered between 1997 and 2000 were smoking at the time of delivery.

- There is a high rate of smoking among younger age groups of women who gave birth, especially those under the age of 25.

- The lowest rate of smoking at the time of delivery was found among women in their 30s.

What is the impact of smoking at the time of delivery?

The Reproductive Care Program has also been actively collecting data to assess the impact of smoking on birthweight. This data is offered in the table below, presented as the percentage of low birthweight babies born to women who were smokers and who were non-smokers from 1997 to 2000.

Low Birthweight Rates (≥ 500 grams and < 2,500 grams) and Smoking 1997-2000				
	1997	**1998**	**1999**	**2000**
Non-smoker	4.0%	4.1%	4.0%	3.8%
Smoker	9.4%	6.1%	9.4%	5.9%

- The above data shows that women who smoke during pregnancy almost double their chances of having a baby with a low birthweight.

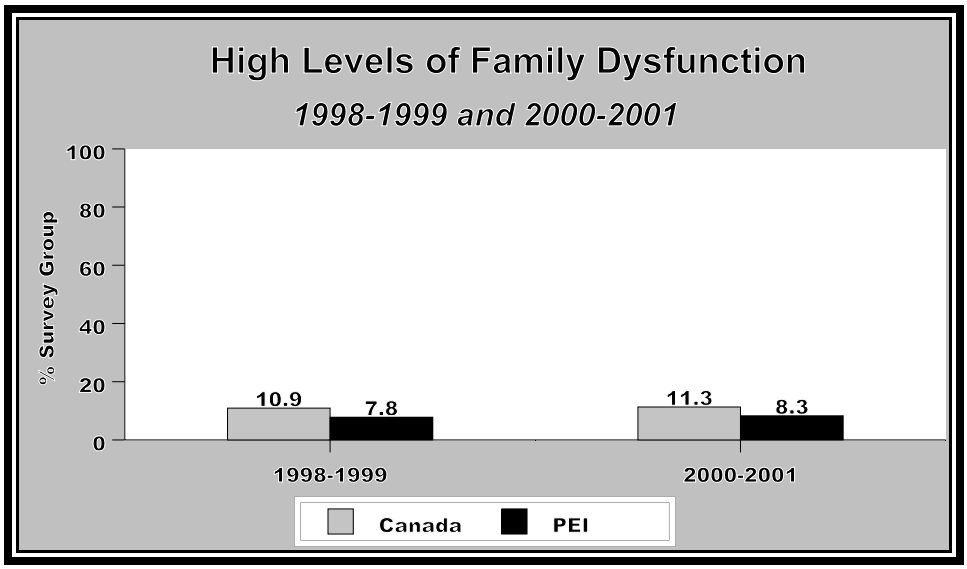
Note: The data above shows some fluctuation in the rate of smokers who have low birthweight babies. Fluctuations such as these will occur among years because even a four-year sample must be considered preliminary. Collecting data on Prince Edward Island necessarily means using a small sample size, and even minor changes in numbers result in large-seeming fluctuations in rates and percentages.

Therefore, data captured over a decade will more accurately reveal the Prince Edward Island trends and allow for a better-informed discussion on the link between tobacco use and this indicator of infant health in our society.

E. Family Functioning

Family functioning data was gathered from the NLSCY using the family functioning scale which provided a global assessment of family functioning around things such as problem-solving, communication, roles, affective involvement, affective responsiveness and behaviour control. Overall, it indicates the quality of relationships between family members. As noted for other indicators in this report, the scale does not reflect clinical diagnoses.

This indicator reflects the proportion of families with high levels of dysfunction, where the families include children five years of age and under.



Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001).

- For both cycles, approximately eight per cent of Island families reported having a high level of dysfunction.

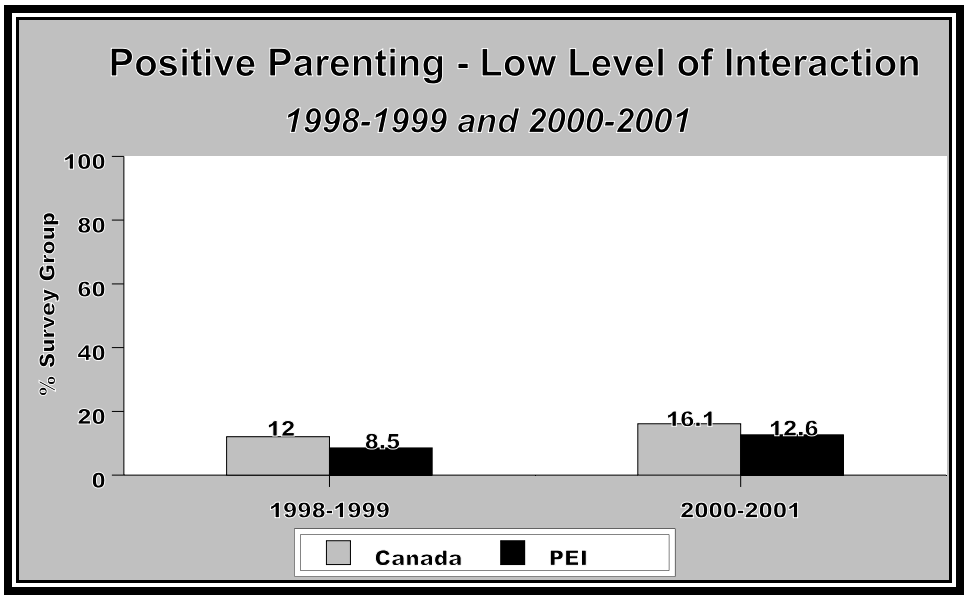
- This rate is below the Canadian average.

Note: For both reporting cycles, Prince Edward Island reported the lowest rate of high family dysfunction among all provinces.

F. Positive Parenting

Positive interaction is a parenting style that is captured in the NLSCY using the parenting scale to measure certain parental behaviours.

The chart below reflects the proportion of children from birth to five years of age whose parents exhibit a low level of what researchers assessed as positive interaction with the child. Reseachers asked the PMK how often they praised the child in proportion to how much they criticized or disciplined the child. They also asked how often the PMK and the child played together, focused attention on each other for five minutes or more and laughed together. Other questions are asked to assess the application and effectiveness of discipline in a child's family. Questions meant to gauge these kinds of interaction typically asked the PMK how often they felt they had trouble "managing the child in general," whether the child could "get out of" punishment, or if the PMK had to discipline the child repeatedly for the same thing. They were asked questions about how often they raised their voice, scolded the child or calmly discussed problems regarding the child's behaviour.



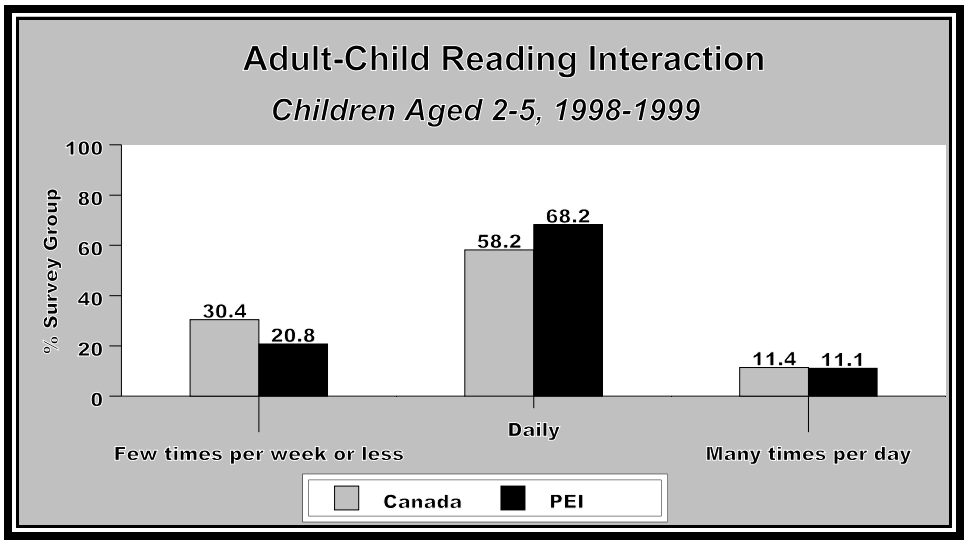
- Very few Island children surveyed by the NLSCY have a low level of interaction with their parent, and this rate is below the rate for Canada.
- The percentages of children on PEI and in Canada who experience a low level of interaction with their parent have risen since the last reporting cycle.

Note: For the 2000-2001 data, PEI scores in the "middle," fifth out of 10 provinces for this indicator. Whereas in 1998-1999, the Island had the third best placing among provinces regarding parent-young child interaction.

G. Reading by Adult

"Reading by adult" refers to the child's exposure to reading activities with a parent or another adult (and therefore should not be interpreted to refer specifically to parent-child interactions).

In 1998-1999, the indicator was designed to reflect how often an adult reads to the child or listens to the child read. The age group surveyed was children aged two to five years.

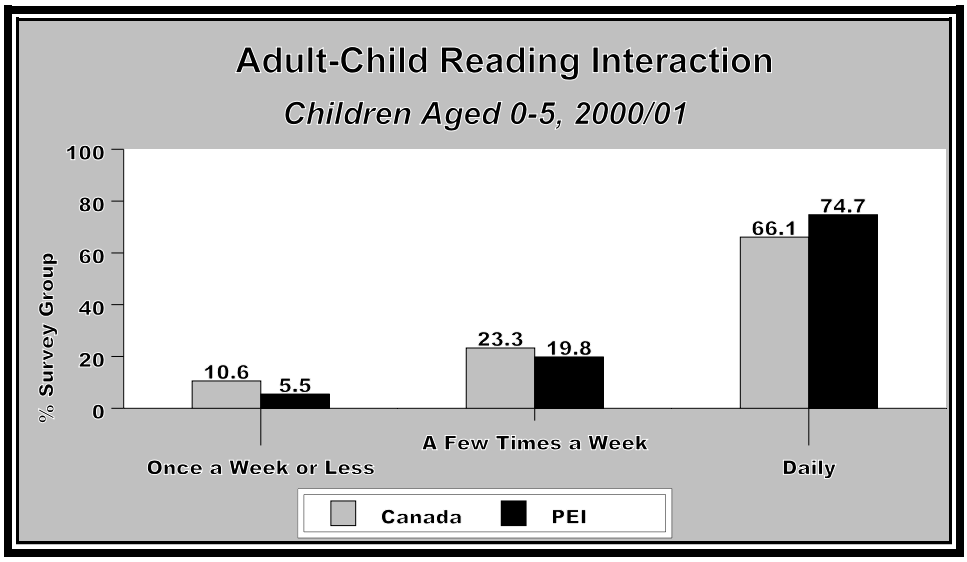


- In 1998-1999, the survey revealed that close to 70 per cent of Island children aged two to five years of age were read to, or were able to read to an adult, on a daily basis.

- These results for 1998-1999 indicate that only about one in 10 children were read to multiple times in a day for both PEI and across Canada.

The second survey conducted in 2000-2001 included children from birth to five years of age, and framed the questions somewhat differently.

For this reporting cycle, researchers captured the rates of reading interaction at intervals of once per week, a few times a week or daily. The questions which sought to capture reading interaction many times per day were dropped.



- In both cycles, the rate of daily reading interaction is higher than the Canadian average.

5. *Community-related Indicators*

This section focuses on the child's neighbourhood, seen here as not only a geographical unit, but as a dynamic environment that exerts many influences upon its residents, particularly children. There are many factors within a neighbourhood that can affect a child's health and well-being. Neighbourhood influences can be socio-economic as in the rate of lone-parent families or levels of financial support. This can refer to physical factors, such as general neighbourhood cleanliness or the conditions of buildings. It can also refer to psychological factors, such as the cohesiveness felt between and among those living in the community or the sense of safety a child feels in the community and when among neighbours.

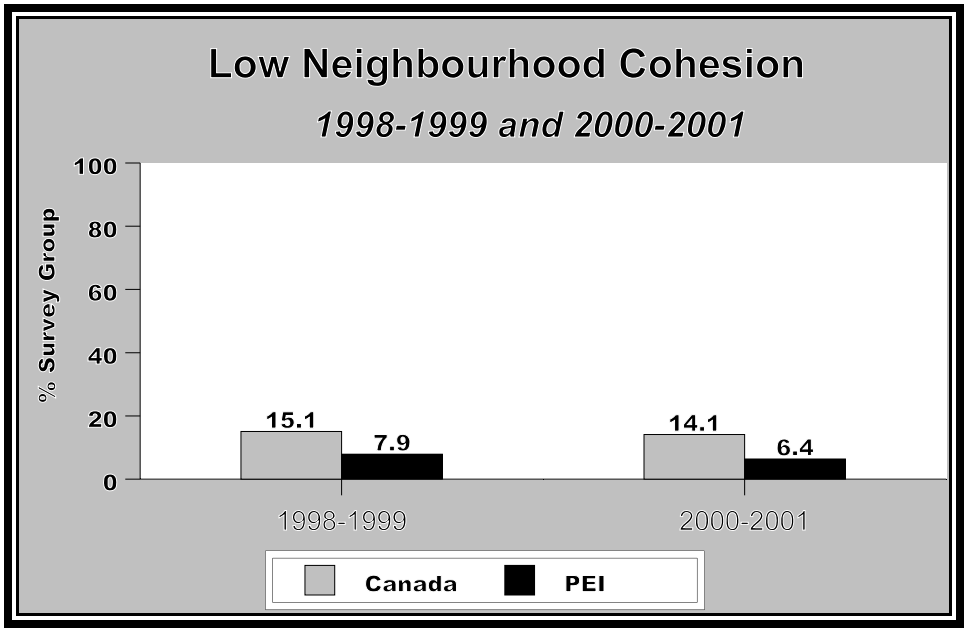
A. Neighbourhood Satisfaction, Safety and Cohesion

Information from the NLSCY on neighbourhood cohesion is presented below as well as two indicators which assess socio-economic risks and physical conditions in neighbourhoods.

i) Neighbourhood Cohesion

Neighbourhood Cohesion data was gathered from the NLSCY survey using the neighbourhood scale to assess the presence or absence of certain neighbourhood characteristics. For example, researchers asked parents about the social unity of the child's neighbourhood, the availability of professional guidance and supports from spiritual or religious leaders and communities. They also asked questions about whether the family had family and friends who help them and their children feel safe, secure and happy.

This indicator reflects the proportion of children from birth to five years of age whose neighbourhoods are characterized by lower levels of social cohesion.



Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001).

- A very low rate of respondents on Prince Edward Island ranked their community as having a low level of neighbourhood cohesion.

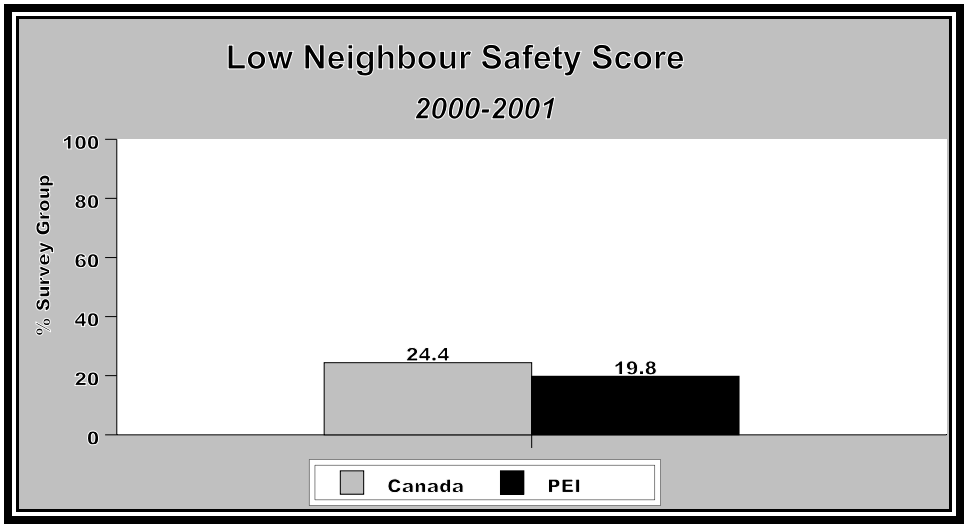
- The perception of low neighbourhood cohesion among PEI parents is about half the rate of that reported in the Canadian average in both years surveyed.

In addition, among all provinces, Prince Edward Island families with young children reported the fewest concerns about low neighbourhood cohesion in 2000-2001.

ii) Neighbour Safety Score

For 2000-2001, the NLSCY expanded its assessment of how safe communities are for children by introducing the Neighbour Safety Score as an indicator of child well-being. Researchers accomplished this by expanding the neighbourhood cohesion questionnaire to capture specific information on neighbour relations. For instance, they asked the study participants whether the adults in the neighbourhood are people that children can look up to. They asked if neighours in their areas were willing to help each other out, and whether they felt their neighbours would "keep their eyes open for possible trouble" if they were away from home.

The following indicator reflects the answers by showing the number of respondents who depicted "low neighbour safety" in their communities.



- A lower rate of Prince Edward Island families surveyed ranked their communities with a low neighbour safety score than the Canadian average.

In addition, out of all provinces, Prince Edward Island reported the second-best score for neighbour safety. The province with the fewest reported a rate of 14.6 per cent.

Technical Notes to the Indicators

1. Physical Health

A. Infant Mortality

Infant Mortality is one of the 11 common indicators and fulfils the Early Child Development communiqué reporting commitment. The data provided here is for 1980 to 2000.

Source: Canadian Vital Statistics – Birth Database (Statistics Canada); Mortality, Summary List of Causes (Statistics Canada).

Exclusions: Births with unknown gestational age and gestational age less than 20 weeks; births to non-Canadian residents.

The data for this indicator is derived from provincial and territorial vital statistics registries. The data also includes deaths of Canadian residents occurring in the United States.

B. Pre-Term Birthweight

Source: Canadian Vital Statistics – Birth Database (Statistics Canada); Mortality, Summary List of Causes (Statistics Canada).

Exclusions: Births with unknown gestational age and gestational age less than 20 weeks; births to non-Canadian residents.

For the 2000 information, Statistics Canada reports data quality concerns regarding Ontario data.

C. Healthy Birthweight

Low birthweight and high birthweight are two of the 11 common indicators and fulfils the Early Child Development communiqué reporting commitment. The data presented here includes the same time frame as the 2000/2001 NLSCY cycle 4 data for many of the other child well-being indicators.

Source: Canadian Vital Statistics – Birth Database (Statistics Canada)

The low birthweight rate = (number of live births weighing < 2,500g/number of all live births) * 100.

Note: For low birthweight rates, weights <500 grams are included.

Exclusions: Births with unknown birth weight; births to non-Canadian residents.

The data for this indicator is derived from provincial and territorial statistics registries. The form for the registration of a live birth is typically completed by the parent, who is responsible for filing it with the local or provincial/territorial registrar. In most provinces, the physician or birth attendant must also file a "Notice of Birth" with the local or provincial/territorial registrar.

D. Immunization

Immunization is one of the 11 common indicators and fulfils the Early Child Development communiqué reporting commitment.

Source: Division of Immunization and Respiratory Diseases, Health Canada

E. Breastfeeding

Source: NLSCY, Master File (Statistics Canada), Cycles 1, 2 and 3 (1994/95, 1996/97, 1998-1999), Parent Questionnaire.

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

Note: Data from Prince Edward Island, Cycle 2 (1996/1997, had a coefficient of variation from 16% to 33.3%. This means the sample size was relatively small, which sometimes results in fluctuations in the rate from year to year, and NLSCY recommends interpreting the data with caution.

2. Safety and Security

A. Injury Mortality

Source: Canadian Vital Statistics (Statistics Canada) – Mortality, Summary List of Causes, 1998, 1999, 2000.

Exclusions: Non-Canadian residents.

B. Injury Hospitalization

Source: This data is managed by Canadian Institute for Health Information (CIHI) – hospital records. However, it remains the property of the respective hospital.

Note: Data for 1998 refers to the 1998-1999 fiscal year and data for 1999 refers to 1999-2000.

3. Early Development

A. Physical Health and Motor Development

Motor and social development is one of the 11 common indicators and fulfils the Early Child Development communiqué reporting commitment.

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Parent Questionnaire.

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

B. Emotional Health

Emotional problems/anxiety, Hyperactivity – Inattention and Physical Aggression/Conduct disorder are three of the 11 common indicators and the data presentation and analysis fulfills the Early Child Development communiqué reporting commitment.

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Parent Questionnaires; data presented is weighted; data based on provinces only.

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

C. Social Knowledge and Competence

i. Personal-Social Behaviour

Personal-social behaviour is one of the 11 common indicators (assessed and referred-to in previous reporting as "prosocial behaviour") and fulfils the Early Child Development communiqué reporting commitment.

The Personal-Social Behaviour "cut-off" was established by taking the scale score that is one standard deviation below the mean based on cycle 4 data for children in all provinces.

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Parent Questionnaire/Ages and Stages Questionaire.

Exclusions: Children living in the territories; children living on reserve; children living in institutions; children age four to five for whom the PMK did not provide consent for the PPVT-R to be administered.

Note: The personal score below the cut-off for cycle 2000-2001 is categorized as unacceptable data quality and the data has been suppressed.

D. Language Skills

Language skills comprise one of the 11 common indicators and fulfils the Early Child Development communiqué reporting commitment.

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Peabody Picture and Vocabulary Test – Revised (PPVT-R).

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

4. Family-Related Indicators

A. Parental Education

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Parent Questionnaire.

Exclusions: Children whose PMK (or spouse of the PMK) is not a biological, step, adoptive or foster father; children living in the territories; children living on reserve; children living in institutions.

B. Level of Income

Source: (Statistics Canada – Longitudinal Administrative Databank (LAD).

Exclusions: Non-taxfilers.

Note: The data presented shows the percentage of families below the after-tax LIM.

C. Parental Health – Depression

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999), Parent Questionnaire; data presented is weighted; data based on provinces only.

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

D. Parental Health – Tobacco Use During Pregnancy

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Parent Questionnaire; data presented is weighted; data based on provinces only.

Exclusions: Children age two to five; children living in the territories; children living on reserve; children living in institutions.

E. Family Functioning

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Parent Questionnaire; data presented is weighted, data based on provinces only.

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

F. Positive Parenting

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Parent Questionnaire; data presented is weighted; data based on provinces only.

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

G. Reading by Adult

Source: NLSCY, Master File (Statistics Canada), Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Parent Questionnaire; data presented is weighted; data based on provinces only.

Exclusions: Children age zero to one, children living in the territories; children living on reserve; children living in institutions.

Note: The data for cycle 4, "Once a week or less" is of a small sample size that Statistics Canada labels of "marginal" quality. Not designed for small sample sizes, their methodology requires appending the qualifier: "while this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it."

5. Community-Related Indicators

A. Neighbourhood Satisfaction, Safety and Cohesion

i. Neighbourhood Cohesion

Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Master File, Parent's Questionnaire; data presented is weighted; data based on provinces only.

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

ii. Neighbour Safety Score

Source: NLSCY, Cycle 3 (1998-1999) and Cycle 4 (2000-2001), Master File, Parent's Questionnaire; data presented is weighted; data based on provinces only.

Exclusions: Children living in the territories; children living on reserve; children living in institutions.

Children's Working Group

The Children's Working Group reaches a number of community and government organizations including the following:

Association for Community Living
Atlantic Network for Injury Prevention
Boys and Girls Club of PEI
Cap enfants Family Resource Centre
Carousel Family Resource Centre
CHANCES Family Resource Centre
Charlottetown City Police
Community Mental Health
Community Legal Information Association
Early Childhood Care and Education – Holland College
Early Childhood Development Association
East Prince Health Region
Eastern School Board
Evangeline Community Health Centre
Fédération des parents de l'Île-du-Prince-Édouard
Four Neighbourhoods Community Health Centre
French School Board
Health Canada
Heart and Stroke Foundation
Human Resources Development Canada
IODE
Kids West Family Resource Centre
Kids 'R First Family Resource Centre
Kings Health Region
Kiwanis Club
Laubach Literary Council
Learning and Reading Partners
Lend A Hand Family Resource Centre
Mi'kmaq Family Resource Centre
PEI Active Living Alliance
PEI Association of Police Chiefs
PEI Bike Helmet Coalition
PEI Breastfeeding Coalition
PEI Cancer Society
PEI Council of the Disabled
PEI Home and School Federation
PEI Literacy Alliance
PEI Literacy Secretariat
PEI Lung Association
PEI Multicultural Council
PEI Newcomers' Association
PEI Recreation and Facilities Association
PEI Red Cross Society
PEI Teacher's Federation
PEI Tobacco Reduction Alliance
PEI Transition House Association
Premier's Action Committee on Family Violence Prevention
Queens Health Region
RCMP
Richmond Centre
Scouts Canada
Société Saint-Thomas-d'Aquin
Southern Kings Community Health Centre
Sport PEI
University of Prince Edward Island
West Prince Health Region
Western School Board