THE EARLY CHILDHOOD POPULATION DATABASES

Document prepared by the Monitoring Committee of the Canadian Council on Learning’s Early Childhood Learning Knowledge Centre
The Early Childhood Development Population Database

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This publication is available electronically on the Canadian Council on Learning’s website at www.ccl-cca.ca/childhoodlearning

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THE ECLKC’s Monitoring and Reporting committee’ role is to identify Early Childhood Development indicators and methods to measure those indicators.
The Canadian Council on Learning is an independent, not-for-profit corporation funded through an agreement with Human Resources and Social Development Canada. Its mandate is to promote and support evidence-based decisions about learning throughout all stages of life, from early childhood through to the senior years.
www.ccl-cca.ca/childhoodlearning
This document was prepared by Constance Milbrath, Jeren Balayeva, and Denise Buote for the Monitoring Committee of the Canadian Council on Learning’s Early Childhood Learning Knowledge Centre

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ECDPopulation Databases
Overview of the document

This document of population databases from around the world focuses on children aged 0-6. Population databases purport to contain data from all individuals in a particular category. In this case, we include indicators from databases that contain the population of children in a given country, province, or state aged six years and younger. Nevertheless, as is often true for census data, estimates must be made for many indicators based on a representative sample of the entire population of interest. For example, Statistics Canada obtains data on age, sex, marital status, mother tongue and relationship to target person on 100% of the Canadian population. However, the bulk of Canadian census information is an estimate based on a 20% sample using additional questions on a long form questionnaire. Typically indicators that are estimated from a sample are documented with this information in the database.

This document should be considered a “working document”, one we hope will continue to evolve over time as new databases are incorporated and outdated databases are removed. Access to and information about these databases was obtained during the year 2007. In most cases, the information should remain stable for several years to come, but there will be some website addresses that no longer function as changes are made to the location of information within sites or sites change web addresses altogether.

Much of the information reported in this document was obtained directly from websites that provide the access to the given database. Therefore, information is often directly quoted with the understanding that by presenting the information along with the website address, a citation has been provided for the material. The sheer volume of information and the desire to maintain precise definitions were primary considerations in this decision. Directly quoted text is most relevant to the short descriptions of indicators contained in a database but also may apply to the overall descriptions for some databases.

Information from individual countries which maintain a database website in English, French or Spanish are included wherever possible. A close or paraphrased translation from French and Spanish to English was made. Translations of other languages were not possible. Information about indicators in databases for countries that do not maintain a database website in English, French, or Spanish are included under the Global databases as part of what the country reports about young children to International agencies such as WHO.
The document has the following format:

- Global Databases
- Pan European Special Projects Databases
- Pan European Databases
- Australian Databases
- New Zealand and Fiji Databases
- Latin American Databases
- Latin American Special Projects Databases
- American Databases
- Canadian Databases

As with any attempt to bring together information from around the world, achieving a consistent format in order to highlight the contents of the databases can prove challenging. In some cases, several databases exist for a given country or region and in other cases, there is minimal or no information. With the goal of presenting the databases in as consistent a manner as possible, the following headings are used for each database from the above regions whenever the relevant information was found available:

**Description of the Databases**
This section highlights the relevant databases that may be available for the region/country. The focus is on an overview of information and in many cases, outlined databases will need to be explored by the reader.

**Indicators in the Databases**
All clearly defined indicators have been pulled out of the information obtained. Indicators have been organized under four categories:

- Demographics and Vital Statistics
- Education and Child Care
- Health
- Child Welfare

**Special Projects, Reports and Initiatives**
Several regions/countries have special projects, reports and/or initiatives that are large in scope and appear to have information of high relevance to the target age groups. These have been included under a separate section.

**Quick Reference Guide**
In order to see “at a glance” the type of information that can be found for each region/area, eight tables have been created. An “X” indicates that indicators or information about the category exists (e.g., Child welfare).

ECDPopulation Databases
REFERENCE GUIDES
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ECDPopulation Databases
GLOBAL DATABASES
Description of Database

Following up on the OECD Babies and Bosses reviews on the reconciliation of work and family life in selected Member States, the OECD has developed an online database on family outcomes and family policies with indicators for all OECD countries.

The database brings together information from different OECD databases (for example, the OECD Social Expenditure database, the OECD Benefits and Wages database, or the OECD Education database, and databases maintained by other (international) organizations.

Development of the Family database is an ongoing process and the release or updating of indicators is not linked to any particular point in time. Not all indicators are presented on a cross-national basis. The first batch of indicators was released at the end of 2006, but the preparation of new indicators for 2007 is ongoing. The database is intended to update existing indicators on a regular basis. Indicators typically present data on a particular issue and also presents relevant definitions and methodology, comparability and data issues, information on sources and, where relevant, the raw data or descriptive information across countries.

Information in the Family database is categorized under 4 broad headings: structure of families, labour market position of families, public policy for families and children, and child outcomes (version December 2006, 11 indicators available).

OECD does not cover education data for children ages 0-5 years. However, all European OECD countries have been harmonizing their data collection and reporting mechanisms to meet the OECD reporting requirements for research and analysis on education. Of the 30 OECD countries, 21 European countries are in full compliance with OECD data requirements.
Demographics and Vital Statistics

- Family size and composition
- Children in families
- Information on living arrangements of children
- Fertility indicators
- Mean age of mother at first childbirth
- Share of births outside marriage
- Teenage pregnancy and motherhood
- Families, children and employment status
- Children in families by employment status
- Distribution of working hours among couple families and adults in couple families individually, by broad hour groups, presence of children, and age of youngest child
- Distribution of working hours among single persons by broad hour groups, presence of children, and age of youngest child

Education and Child Care

- General tax/benefit support for families with children: Public spending on family benefits; Family benefits; Child support (maintenance) systems; Parenting support
- Child-related leave; Key characteristics of parental leave systems; Take-up of leave benefits by mothers and fathers; Additional leave entitlements of working parents
- Formal care and education for very young children: Public spending on childcare and early education; Enrolment in day-care and preschools; Childcare support
- Typology of childcare benefits and net parental fees by family type and income level; Typology of childcare and early education services; Quality of childcare and early education services
- Family- friendly workplace practices
- Workplace hours and time for caring

ECDPopulation Databases
Health

- Child health
- Infant mortality
- Early health indicators
- Low and average birth-weight
- Immunization
- Breastfeeding
- Prevalence of diabetes and asthma among children

Child Welfare

- Child poverty
**Eurostat**

http://europa.eu/

**Description of Database**

Eurostat’s mission is to provide the European Union with a high-quality statistical information service. In addition to cooperating closely with international organizations such as the UN and OECD, Eurostat works with countries outside the EU. A key task for Eurostat is to coordinate the improvement of statistical systems in candidate and developing countries. Special programs have been established with countries in Central and Eastern Europe and the New Independent States of the former Soviet Union. Eurostat also works closely with national statistical offices in Mediterranean countries and in many African countries.

Eurostat collects a wide range of economic and environmental data but also includes some data on population and social conditions. Very little of this data is collected on young children. Below are the variables collected by Eurostat for children aged 0-5.

<table>
<thead>
<tr>
<th>INDICATORS INCLUDED IN EUROSTAT DATABASE</th>
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**Demographics and Vital Statistics**

- Proportion of total population aged 0-14 years
- Life expectancy at birth
- Infant mortality (per 1000 live births)

**Education and Child Care**

- Pre-primary education
  - Programs at level 0, (pre-primary) defined as the initial stage of organized instruction, are designed primarily to introduce very young children to a school-type environment. Upon completion of these programs, children continue their education at level 1 (primary education).
- Four-year-olds in education participation rate (%)
  - This indicator presents the percentage of 4 year olds who are enrolled in education-oriented pre-primary institutions. These

ECDPopulation Databases
institutions provide education-oriented care for young children. They can be either schools or non-school settings (generally come under authorities or ministries who are not responsible for education). They must recruit staff with specialized qualifications in education. Day nurseries, playgroups and day care centres that do not require staff to hold a qualification in education are not included (1998 - 2005).

Health

- Healthy life years at birth, by gender in years
  - The indicator Healthy Life Years (HLY) measures the number of years a person at birth is expected to live in a healthy condition. HLY is a health expectancy indicator that combines information on mortality and morbidity. The data required is the age-specific prevalence (proportions) of the population in healthy and unhealthy conditions and age-specific mortality information. A healthy condition is defined as the absence of limitations in functioning/disability. The indicator is calculated separately for males and females. The indicator is also called disability-free life expectancy (DFLE).

Child Welfare

- Jobless households - children
  - Defined as the share of children aged 0-17 who are living in households whose residents are unemployed. Both the numerators and the denominators come from the EU Labour force survey (1995-2005).

Special Initiatives, Reports and Projects

Europe in figures - Eurostat yearbook 2006-07

Europe in figures - Eurostat yearbook 2006-07 - presents a comprehensive selection of statistical data on the European Union, its Member States and candidate countries. Most data covers the period 1995-2005 and some data includes other countries such as the USA and Japan. With almost 400 statistical tables, graphs and maps, the yearbook addresses areas such as population, education, health, living conditions and welfare, the labour market, the economy, international trade, industry and services, science and technology, the
environment, agriculture, forestry and fisheries, and European regions. The spotlight chapter deals with energy statistics. The paper version includes a CD-ROM with a PDF’d electronic version of the yearbook, Excel formatted tables and graphs, and further information. The yearbook may be viewed as an introduction to European statistics and provides guidance to the vast range of data freely available from the Eurostat website.
Organization of the American States

www.oea.org
www.coordinacion.oea.org

Description of Database

The Organization of the American States (OEA) database includes several “sub-databases”. The OEA’s member states include: Antigua and Barbuda, Argentina, The Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, the United States of America, Uruguay, and Venezuela.

The “Coordination Actions” site enables coordination between countries and works to resolve problems (cases) related to childhood and adolescence that originate in a particular country and may involve others in the region. This website has limited information on demographics of infants and young children on health. Where education is listed, no early child information is indicated. States included in this database are: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Dominican Republic, Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and the Dominican Republic.

INDICATORS INCLUDED IN OEA DATABASE

Demographics and Vital Statistics

(www.coordinacion.oea.org/indicadores_demograficos.aspx)

- Population children under 5 years (thousands) (2003)
- Global Fertility Rate (2003)
- Infant Mortality Rate children under 5 years (2003)
- Infant Mortality Rate children under 1 year (2003)
- Life expectancy at birth (years) 2003

ECD Population Databases
Education and Child Care

- Rate enrollment / attendance primary (%) 1996-2003

Health

- Maternal Mortality (rate per 1000 live births)
- Newborn infants with low birth weight (%) 1995 - 2000
- Children 1 year immunized for Measles
- Children 1 year immunized against Polio

From: Data from Perinatal Information System Database of the Latin American Center for Perinatology and Human Development (CLAP)

Special Projects, Reports and Initiatives

Inter American Children’s Institute

www.iin.oea.org/SIM/english/index.shtml

The Inter-American Institute for Children and Adolescents, founded in 1927, is the Specialized Agency of the Organization of American States. The Institute is responsible for promoting the study of issues related to children, adolescents and families in the Americas. In addition, the Institute generates instruments to solve such issues by providing technical help. The NIR bases its actions on the promotion and protection of the Rights of Children and Adolescents in the inter-American system.

The Institute’s framework for action sets out the activities aimed at building a culture that respects the rights of children, girls and adolescents in the OAS member states, and that contributes to the integral development of children, adolescents and family.

The Inter-American Children’s Institute (IIN), in its capacity as a specialized organization of the Organization of American States (OAS), makes available to the Member States, competent Central Authorities, experts, and other stakeholders, a website containing information on the international abduction of children by one of their parents. This is not a public database. This tool provides specialized information designed to improve both the prevention and resolution of cases related of international child abduction.

ECDPopulation Databases
Database Legal BADAJ

www.iin.oea.org/BADAJ_new/index.shtml

Database “Legal BADAJ” is made available to all Member States nationally and internationally throughout the Inter-American System.

The NIR has developed the Inter-American Information Network of Children and Families (RIIN) which represents 22 countries and comprises more than 120 information centers, through which it gives information services in the field of Child and Adolescent Rights. This network manages the largest database with over 95,000 bibliographic references. Of these references, 13,000 are full text, thereby shaping the Virtual Library of “Dr. Luis Morquio.” You may contact any of the participants’ RIIN Centers to obtain more information about RIIN services.
Organización des los Estados Iboamericanos (OEI)

www.oei.es/quipu

Description of Database

The information available that is relevant to ECD is very limited and related to teacher education at various levels of child education. Information is organized by country, and member countries include: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Spain, Guatemala, Honduras, México, Nicaragua, Panama, Paraguay, Peru, Portugal, Uruguay and Venezuela.
Description of Database

As part of its mission, the UNESCO Institute of Statistics (UIS) focuses on "assistance to Member States to help them improve their statistical and analytical capacities". The availability and quality of data are critically dependent upon the statistical capacities of relevant government departments and national agencies.

The aim of UIS Statistical Capacity Building efforts is to help countries become self-reliant, both financially and institutionally, so that they acquire the expertise to determine their own data needs and priorities. Also prioritized, is to collect this data; to interpret and use it effectively; to undertake research, problem solving and problem formulation; and to sustain capacities.

To strengthen its efforts and to provide cost-effective and efficient support to UIS Member States, the UIS deploys statistical advisers at some UNESCO Regional offices. The UIS collects the data for more than 200 countries from Member States and international organizations.

A Data Quality Assessment Framework, prepared by the UIS and the World Bank, is being used in the diagnostic phase of Statistical Capacity Building work within countries to assess the quality of education statistics, and identify areas in need of strengthening.

**Purpose of the Framework**
The main purpose of the Framework is to provide a flexible structure for the qualitative assessment of education statistics.

A general Data Quality Assessment Framework has been developed by the IMF and statistically applied to a number of different subject matters - including poverty statistics. The World Bank in collaboration with the UNESCO Institute for Statistics has undertaken the application of the framework to education statistics. This approach has been able to describe the general framework independent of the subject matter being applied, and to highlight elements specific to education statistics via embedded boxes. This allows a view of the general framework, while also highlighting the framework’s applicability to education statistics.

The Framework covers all aspects of the statistical environment or infrastructure
in which data are collected, processed, and disseminated, by integrating aspects of the quality of institution and of the quality of products.

Organization of the Framework
The Framework is organized in a cascading structure that progresses from the abstract/general to the more concrete/specific.

The first-digit level defines the prerequisites and five dimensions of quality: integrity, methodological soundness, accuracy and reliability, serviceability, and accessibility. The first-digit level is sub-divided by elements (two-digit level) and indicators (three-digit level).

At the next level, focal issues that are specific to the compilation of statistics for the subject area are addressed. Below each focal issue, key points describe quality features that may be considered in assessing focal issues. The key points are meant to be suggestive, not exhaustive.

Structure of the Framework
The elements and indicators within their respective dimensions are described below.

“Statistical program” refers to the “education statistical program” and “statistical series” refers to the “education data series”, etc.

Prerequisites of quality: Not itself a dimension of quality, however this group of “pointers to quality” includes elements and indicators that have an overarching role as prerequisites, or institutional preconditions for quality statistics. Note that the focus is on the umbrella agency involved in the statistical work. These prerequisites cover the following elements:

Legal and institutional environment, including coordination power within MOE and across different ministries and departments;
Resources available for statistical work; and Quality awareness informing statistical work.

Integrity: Statistical systems should be based on adherence to the principle of objectivity in the collection, compilation, and dissemination of statistics. The dimension encompasses institutional arrangements that ensure professionalism in statistical policies and practices, transparency, and ethical standards. The three elements for this dimension of quality are: (1) professionalism, (2) transparency, and (3) ethical standards.

Methodological soundness: The methodological basis for the production of statistics should be sound and attained by following internationally accepted
standards, guidelines, or good practices. This dimension is necessarily dataset-specific, reflecting different methodologies for different datasets. This dimension has four elements: (1) concepts and definitions, (2) scope, (3) classification/sectorization, and (4) basis for recording.

Accuracy and reliability: Statistical outputs should sufficiently portray the reality being measured. The source data should provide an adequate basis to compile sound statistics and techniques, and regularly assessed and validated source data, intermediate data, and statistical outputs. The five elements of this dimension cover: (1) source data, (2) statistical techniques, (3) assessment and validation of source data, (4) assessment and validation of intermediate data and statistical outputs, and (5) revision studies.

Serviceability: Statistics should cover relevant information on the subject field, be disseminated in a timely fashion with an appropriate periodicity, be consistent internally and with other major datasets, and follow a regular revision policy. The four elements for this dimension are: (1) relevance, (2) timeliness and periodicity, (3) consistency, and (4) revision policy and practice.

Accessibility: Ensure that data and metadata is presented in a clear and understandable manner on an easily available and impartial basis, that metadata is up-to-date and pertinent, and that a prompt and knowledgeable support service is available. This dimension has three elements: (1) data accessibility, (2) metadata accessibility, and (3) assistance to users.

Data Centre site: One can access data and rely on either Predefined Tables or Custom Tables to build statistical tables related to UNESCO’s fields of action. The Data Centre contains over 1,000 types of indicators and raw data on education, literacy, science and technology, culture and communication, and demographic and socio-economic (not included under Predefined Tables).

One can build a table by country or grouping of countries to access data in any of the available four areas and over 1,000 categories.

**INDICATORS INCLUDED IN UNESCO DATABASE**

**Demographics and Vital Statistics**

- Infant mortality rates
- Life expectancy at birth

ECDPopulation Databases
Education and Child Care
(predefined tables)

- Report: Table 3B: Enrolment by ISCED level Summary [includes pre-primary]
- Report: Table 3C: Enrolment of pupils of the official age in pre-primary, primary and secondary education (ISCED 0-3) Summary
- Report: Table 4: Teaching staff by ISCED level Summary [includes pre-primary]
- Report: Table 5: Enrolment ratios by ISCED level Summary [includes pre-primary]
- Report: Table 7: Measures of children out of school Summary [includes pre-primary enrolment of children who should be in primary]
- Report: Table 8: School life expectancy (approximation method) Summary;
- Report: Table 11: Indicators on teaching staff at ISCED levels 0 to 3 Summary [includes pre-primary]
- Report: Table 20A: Regional average of enrolment by ISCED level Summary
- Report: Table 20C: Regional average of teaching staff by ISCED level Summary
- Report: Table 20D: Regional average of enrolment ratios for pre-primary to tertiary education (ISCED 0-6) Summary
- Report: Table 20F: Regional average of indicators on teaching staff by ISCED level Summary
- Report: Table 20G: Regional average of school life expectancy (approximation method) by ISCED level Summary

Other indicators include:
- Participation
- Entry

ECDPopulation Databases
➢ Completion
➢ Progression
➢ Population
➢ Expenditure
➢ Teachers
  • Of possible relevancy to age 5 and under would be Tables for each main category built by: Female participation; School age enrolment; Enrolment in pre-primary; Enrolment in primary; Gross enrolment ratio; Net enrolment rate; School life expectancy; Out-of-school children; Student mobility indicators; Student mobility country of origin; Program orientation; Private education
Description of Database

UNICEF reports statistics in the following areas: Child survival and health: Child Nutrition, Maternal Health, Education (See Appendix A at the end of this document for complete list of available variables related to children 0-5)

INDICATORS INCLUDED IN UNICEF DATABASE

Demographics and Vital Statistics

- Child Mortality by Cause of Death

Child Mortality Under 5 Country Data

- Definition of the indicator: The under-five mortality rate is the probability (expressed as a rate per 1,000 live births) that a child born in a specified year dies before reaching the age of five if subject to current age-specific mortality rates.

- Methods of computation: The U5MR can be calculated using methodologies that depend on the type of data available. In practice, data can be obtained from registration of births and deaths via vital registration systems, data from national population census and/or data collected via household surveys. When data collected via vital registration systems is of good quality, the U5MR can be easily estimated by observing the survival status of different cohorts along time and to specific ages since the moment of birth. U5MR can be derived from household survey data using direct or indirect methods. The direct method uses data collected on birth histories of women of childbearing age and produces the probability of dying before age five of children born alive to women of childbearing age, during five year periods before the survey (child ages 0-4, 5-9, etc.). The indirect method uses the Brass method which converts the proportion dead of children ever born reported by women in age groups 15-19, 20-24,..., 45-49 into estimates of probability of dying before attaining certain exact childhood ages.

- Process for obtaining data and estimation: UNICEF compiles U5MR
country estimates derived from all sources and methods of estimation obtained either from standard reports, direct estimation from micro data sets, or from UNICEF’s yearly exercise, CRING1. In order to sort out differences between estimates produced from different sources, with different methods, UNICEF developed, in coordination with WHO, the WB and UNSD2, an estimation methodology that minimizes the errors embodied on each estimate and maximizes the consistency of trends over time. Since the estimates are not necessarily the exact values used as input for the model, they are often not recognized as the official U5MR estimates used at the country level.

• Data availability including timing: Vital registration data is available on a yearly basis but often is published at the country level with a lag of 2 or more years. Unfortunately, vital statistics are unreliable in most developing countries. Population censuses are regularly conducted every ten years and results are published within 1-3 years after the population count. Households surveys, such as DHS and MICS, are generally implemented every 3-5 years with results published within a year of field data collection. It is important to mention that on average, the most recent U5MR estimates from household surveys refer to 2.5 years before the time of the survey or 3.5 years at the moment of publication of findings.

• U5MR estimates from the Inter Agency Group for Mortality Estimation (IAGME) refer to the year before the publishing date of the respective agency (in the case of UNICEF for example, the 2006 State of the Worlds Children published in November 2005 includes U5MR estimates corresponding to the year 2004). Recent estimates are consistent with the trend observed during the last 30 years.

• Treatment of “missing” values: The most recent U5MR estimates produced by the IAGME are extrapolation of observed trends obtained from observed U5MR values derived from different data sources and methods.

• Regional and global estimates: U5MR estimates are produced and presented by region and globally only if data is available for at least 50% of the region or the total population of the countries considered. Estimates are not included if this rule is not accomplished.

  • Comments and limitations (data quality): In the majority of developing countries, U5MR estimates are obtained from household surveys and therefore have attached confidence intervals that need to be considered when comparing values along time or across countries. Similarly, these estimates are often affected by sampling errors that may affect equally recent levels and trends of U5MR. This

**Education and Child Care**

(Data can be downloaded by country and trends from 1980-2005 are outlined)

- Pre-primary enrollment: Male and female gross enrollment rate (GER) and net enrollment rate (NER).
- Primary attendance or enrollment: Male and female net enrollment rate (NER), male and female net attendance rate (NAR). The NER is taken from administrative records compiled by UIS; the NAR is calculated from survey data.
- Survival rate to grade 5: Male and female survival rate to grade 5. This indicator is taken from administrative records (UIS) and calculated from household survey data. The maximum value for the survival rate is 100%, where all children enter grade 1 reach grade 5, with or without repeating.
- Pupil/teacher ratio: Pupil/teacher ratio in primary and secondary education. The pupil/teacher ratio is taken from administrative records (UIS). Smaller values indicate smaller class sizes.
- Education expenditures.

**Data Sources for Education Data**

- Demographic and Health Surveys (DHS): ORC Macro, various years, [http://www.measuredhs.com](http://www.measuredhs.com)
Health

- **Pneumonia**
  - Most of this data comes from the Demographic and Health Survey and Multiple Indicator Cluster Survey done in some countries between 2000 and 2005. Some of these surveys date back to the early and mid 1990s for a few countries. Many countries do not have reported data (e.g., China). Note that the reported figures do not include deaths due to pneumonia in the first four weeks of life, the neonatal period.

- **Diarrhoeal Disease**
  - The data for this indicator comes from Demographic and Health Survey and Multiple Indicator Cluster Survey for most countries. Bahrain, UAE, Kuwait, Qatar and Saudi Arabia use the Gulf Family Health Survey. A number of Latin American countries, Belize, Ecuador, El Salvador, Honduras, and Paraguay use the Centers for Disease Control data collection format. The prevalence of diarrhoea may vary by season. Country surveys were administered at different times, rendering the diarrhoeal prevalence data incomparable between countries. Most of these surveys were before between 1995-1998.

- **Malaria**
  - The data for this indicator comes from Demographic and Health Survey and Multiple Indicator Cluster Survey for most countries, reanalyzed in 2000 by UNICEF. Some countries provide their own reports.

  - The Roll Back Malaria Initiative has formed a Malaria Monitoring and Evaluation Reference Group (MERG) which is co-chaired by WHO and UNICEF. The primary purpose of the Malaria MERG is to coordinate and harmonize the monitoring activities among the relevant UN agencies, to address specific technical issues, produce state-of-the-art measurement tools, advocate for monitoring activities and enhance support for capacity building at country level (for more information see www.rbm.who.int).

- **Immunization**
  - The annual review of national immunization coverage has produced figures indicating the status of immunization in each country at the beginning of the new millennium. This will guide national and global efforts to further reduce the morbidity, disability and mortality associated with vaccine-preventable diseases (polio eradication, measles control and maternal and neonatal...
tetanus elimination; coverage levels with diphtheria-tetanus-pertussis vaccine (DPT) are considered one of the best indicators of health system performance). Data is derived from the following: reported data by member States to WHO, historical database maintained by UNICEF and National Representative Household Survey Reports (published and published).

- Underweight Prevalence
- Underweight Prevalence by Gender and Residence
- Stunting Prevalence
- Wasting Prevalence
  - Child nutrition data (four above indicators) comes from the Demographic and Health Survey and Multiple Indicator Cluster Survey for many countries done between 1999 and 2004. Many other countries provide their own reports through survey data undertaken in the country.
- Percent of births attended by skilled health personnel (doctor, nurse or midwife)
- Percent of women aged 15-49 years attended at least once during pregnancy by skilled health personnel (doctor, nurse, midwife).

Special Projects, Reports and Initiatives

UNICEF Innocenti Research Centre (IRC)

www.unicef-irc.org

The UNICEF Innocenti Research Centre (IRC) in Florence, Italy, was established in 1988 to strengthen the capacity of UNICEF and its cooperating institutions to respond to the evolving needs of children and to develop a new child-centered global ethic. It promotes the effective implementation of the Convention on the Rights of the Child, in both developing and industrialized countries, thereby reaffirming the universality of children’s rights and of UNICEF’s mandate.

By providing a gathering place to stimulate reflection on the rights of the child, the Centre has collected data related to the situation of children and the implementation of their rights. UNICEF IRC has developed a good number of databases and tools based on the Convention on the Rights of the Child as a common basis to retrieve documents and information related to children.
The meta-search engine transmits a search simultaneously to the databases. Within a few seconds, results from all the search engines queried are received.

The following databases are available:

1. **Children and armed conflict**
   Research documents on children and armed conflict including the research outputs of Network partners.
   [www.childreninarmedconflict.org](http://www.childreninarmedconflict.org)

2. **Database of documents on child trafficking**
   Users can research by title, author, editor/organization, topic, keywords, geographic descriptors and year of publication.
   [www.childtrafficking.org/eng/database.html](http://www.childtrafficking.org/eng/database.html)

3. **Child Friendly Cities Database**
   Data collection and analysis are key activities of the CFC Secretariat. Field research findings and existing data are processed in the CFC Database and provide a knowledge base for the global Child Friendly Cities Initiative. Through the CFC network, data are collected on the role played by cities in the fulfillment of child rights, especially child participation and access to services. Information is regularly processed, analyzed and updated. Data are made available to municipalities, communities, children's groups and other interested partners to inform planning procedures, advocacy initiatives and research activities needed to build a CFC.
   [www.childfriendlycities.org/database/index.html](http://www.childfriendlycities.org/database/index.html)

**TransMONEE Database**

[www.unicef-irc.org/databases/transmonee/](http://www.unicef-irc.org/databases/transmonee/)

The TransMONEE Database collects and stores data and statistical information on social and economic issues relevant to the welfare of children, young people and women in countries of CEE/CIS. The database is updated every year due to the collaboration of National Statistical Offices (NSOs) in the countries of CEE/CIS. The published database presents only a selection of the larger amount of indicators annually collected. Data coverage: The 2007 version of the public-use database contains 154 economic and social indicators divided into ten topics (Population, Birth Rates, Child and Maternal Mortality, Life Expectancy and Adult Mortality, Family Formation, Health, Education, Child Protection, Crime, Economy). The data series generally began in 1989; some child protection data
are available only since 2000. TransMONEE 2007 contains data for the following countries: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, The former Yugoslav Republic of Macedonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Montenegro*, Moldova, Poland, Romania, Russian Federation, Serbia*, Slovakia, Slovenia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan. Montenegro ceded from the State Union of Serbia and Montenegro: data presented in the TransMONEE database 2007 are for Serbia and Montenegro pre-cession.

Data sources: Most data are collected directly from National Statistical Offices using a standardized template. Indicators are calculated by the TransMONEE database manager on the base of raw data and using standardized methodologies. Additional data are obtained from international organizations. Due to the different data sources for some indicators, the data presented in the TransMONEE database may diverge from those presented in other UNICEF publications and databases. As with any cross-national statistical database, concepts and measures may differ widely between countries. Therefore, users are strongly encouraged to consult the notes on specific data.

**UNICEF Data**

Websites:  
[www.childinfo.org/](http://www.childinfo.org/)  
[www.childinfo.org/index.html](http://www.childinfo.org/index.html)

The website contains a full range of statistical information made available by UNICEF. These official global statistical databases are published annually in UNICEF’s flagship publication, The State of the World’s Children. This publication reports on international goals and targets such as the Millennium Development Goals (MDGs) and the World Fit for Children (WFFC) commitments. The website also supports the Multiple Indicator Cluster Surveys (MICS) by providing the full set of needed resources. The MICS enables countries to produce nationally representative and statistically sound data to monitor national and international targets. Along with the Demographic and Health Surveys, MICS is a major source of global information that provides data for monitoring about half of the MDG indicators.
World Health Organization (WHO)

www.who.int/research/en/

Description of Database

All countries that are Members of the United Nations may become members of WHO by accepting its Constitution. Other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly. Territories which are not responsible for the conduct of their international relations may be admitted as Associate Members upon application made on their behalf by the Member or other authority responsible for their international relations. Members of WHO are grouped according to regional distribution (193 Member States).

WHO Statistical Information System (WHOSIS) contains national statistics for 50 core indicators on mortality, morbidity, risk factors, service coverage, and health systems.

The core set of indicators was selected on the basis of their relevance to global health, the availability and quality of the data, and the accuracy and comparability of estimates. The statistics for the indicators are derived from an interactive process of data collection, compilation, quality assessment and estimation occurring among WHO’s technical programs and its Member States. During this process, WHO strives to maximize the accessibility, accuracy, comparability and transparency of health statistics.

Regional statistics are also available for the core set of indicators through the WHO regional office: Regional office for Africa (AFRO); Regional office of the Americas (AMRO); Regional office for South East Asia (SEARO); Regional office for Europe (EURO); Regional office for the Eastern Mediterranean (EMRO); Regional office for the Western Pacific (WPRO)

Regional statistics can be obtained from the WHO Regional Offices listed below. Note that countries represented in each region provide the statistics for the Global WHO database and the regional databases. Therefore, variables are consistent throughout regions.

Regional office for Africa (AFRO) - AFRO - Global Health Atlas
www.afro.who.int/

ECDPopulation Databases
In 1995, the Regional Core Health Data and Country Profile Initiative was launched by the Pan American Health Organization / Regional Office of the World Health Organization (WHO) to monitor the attainment of health goals and compliance with the mandates of the Member States, in addition to ensuring the availability of a basic set of data to be collected annually that would make it possible to characterize the health situation and trends in the countries of the Region of the Americas. In 1997, the XL Directing Council of the Pan American Health Organization adopted the Resolution CD40.R10 on the Collection and Use of Core Health Data to:

- Evaluate the health status of the population and health trends,
- Provide empirical basis for identifying the population groups with greater health needs,
- Stratify epidemiological risk,
- Determine critical areas, and
- Examine the response of the health services to provide input for policy-making and setting priorities in this field.
Demographics and Vital Statistics

- **Life expectancy at birth (years):**
  - Data sources: Vital registration, census and surveys: Age-specific mortality rates required to compute life expectancy at birth.
  - Methods of estimation: WHO has developed a model life table based on about 1800 life tables from vital registration judged to be of good quality.
  - For countries with vital registration, the level of completeness of recorded mortality data is assessed and mortality rates are adjusted accordingly. For countries where the information system provided a time series of annual life tables, parameters from the life table were projected using a weighted regression model, giving more weight to recent years. Projected values of the two life table parameters were then applied to the modified logit life table model, where the most recent national data provided an age pattern, to predict the full life table. In case of inadequate sources of age-specific mortality rates, the life table is derived from estimated under-5 mortality rates and adult mortality rates that are applied to a global standard (defined as the average of all the 1800 life tables) using a modified logit model.

- **Healthy life expectancy (HALE) at birth (years):**
  - Definition: Average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.
  - Data sources: Death registration data reported annually to WHO: Mortality data for calculation of life tables. For countries without such data, available survey and census sources of information on child and adult mortality are analysed and used to estimate life tables.
  - WHO Global Burden of Disease (GBD) study, WHO Multi-Country Survey Study (MCSS) and World Health Survey (WHS). Estimation of prevalence data. The GBD study draws on a wide range of data sources to develop internally consistent estimates for the incidence, prevalence, duration and years lived with disability for 135 major causes. The World Health Survey, carried out by WHO in more than 70 countries, uses anchoring vignettes to maximize comparability of self-report capacities for a set of core health domains. It also includes a health state valuation module for assessing the severity of reported health states.

- **Probability of dying aged < 5 years per 1000 live births (under-five mortality**
rate), and Neonatal mortality rate (per 1000 live births):

- **Under-five mortality rate** is the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates of that period.

- **Infant mortality rate** is the probability of a child born in a specific year or period dying before reaching the age of one, if subject to age-specific mortality rates of that period.

- **Live birth** refers to the complete expulsion or extraction from its mother as a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

- Data sources: Age-specific mortality rates among children are calculated from birth and death data derived from civil registration, census, and/or household surveys:
  - Civil registration: Number of deaths by age and numbers of births and children in each age group are used to calculate age specific rates. This system provides annual data.
  - Census and surveys: An indirect method is used based on questions to each woman of reproductive age as to how many children she has ever given birth to and how many are still alive. The Brass method and model life tables are then used to obtain an estimate of under-five mortality.
  - Surveys: A direct method is used based on birth history - a series of detailed questions on each child a woman has given birth to during her lifetime. To reduce sampling errors, the estimates are generally presented as period rates, for five or 10 years preceding the survey.

- Distribution of causes of death among children aged < 5 years (percentage of total):
  - Definition: The causes of death are those that are entered on the medical
certificate of cause of death in countries and recorded by the civil (vital) registration systems. For the analyses, we have used the concept of the 'underlying cause of death' as defined by ICD (WHO, 1992). In countries with incomplete or no civil registration, causes of death are those reported as such in epidemiological studies that use verbal autopsy algorithms to establish cause of death.

- Underlying cause of death has been defined by ICD (WHO, 1992) as “(a) the disease or injury which initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury”.

- Data sources: WHO regularly receives mortality-by-cause data from Member States, as recorded in national civil (vital) registration systems. These statistics were therefore analysed to obtain the distribution of child deaths by cause in 72 countries where those systems are judged to be sound (on the basis of reliable diagnostic procedures and standard application of cause coding that follows ICD rules as applied to death certificates) and have coverage rates of 85% or above, all of which are high- or middle-income countries. For countries with an incomplete or no vital registration system, epidemiological studies and statistical modelling were used extensively.

- Quality of cause-of-death information

- Accurate and timely data on deaths and causes of death are essential. But for more than a quarter of the world’s population - largely in Africa, South-East Asia and the Middle East - there is no recent data available.

- The quality of the information suffers as proper systems for death registration operate in only 29 of 115 countries that report such statistics to WHO. In the remaining countries, mortality statistics suffer from incomplete registration of births and deaths, and incorrect reporting of the cause of death and age.

Health

- Immunization coverage among 1-years-olds
  - Definition: Measles immunization coverage is the percentage of one-year-olds who have received at least one dose of measles containing vaccine in a given year. For countries recommending the first dose of measles among

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children older than 12 months of age, the indicator is calculated as the proportion of children less than 24 months of age receiving one dose of measles containing vaccine.

- **DTP3 immunization coverage** is the percentage of one-year-olds who have received three doses of, the combined diphtheria and tetanus toxoid and pertussis vaccine in a given year.

- **HepB3 immunization coverage** is the percentage of one-year-olds who have received three doses of Hepatitis B3 vaccine in a given year.

- **Data Sources** - Administrative data: Reports of vaccinations performed by service providers are used for estimates based on administrative data service providers (e.g. district health centres, vaccination teams, physicians). The estimate of immunization coverage is derived by dividing the total number of vaccinations given by the number of children in the target population, often based on census projections.

- **Household surveys:** Survey items correspond to children’s history in coverage surveys. The principle types of surveys are the Expanded Programme on Immunization (EPI) 30-cluster survey, the UNICEF Multiple Indicator Cluster Survey (MICS), and the Demographic and Health Survey (DHS).

  - **Antenatal care coverage (percentage)**
    - **Definition:** Percentage of women who used antenatal care provided by skilled health personnel for reasons related to pregnancy at least once during pregnancy, as a percentage of live births in a given time period.

    - Antenatal care constitutes screening for health and socioeconomic conditions likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them.

  - **Skilled birth attendant**
    - **Definition:** Births attended by skilled health personnel.

    - A skilled birth attendant is an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and

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newborns. Traditional birth attendants, trained or not trained, are excluded from the category of skilled attendant at delivery.

• In developed countries and in many urban areas in developing countries, skilled care at delivery is usually provided in a health facility. However, births can take place in a range of appropriate places, from home to tertiary referral centres, depending on availability and need, and WHO does not recommend any particular setting for giving birth. Home delivery may be appropriate for a normal delivery, provided that the person attending the delivery is suitably trained and equipped and that referral to a higher level of care is an option.

• Data sources: Household surveys: birth history—detailed questions on the last-born child or all children a woman has given birth to during a given period preceding the survey (usually 3 to 5 years), and women are asked about the use of antenatal care. The number of live births to women surveyed provides the denominator.

• Routine health-service statistics: number of women receiving antenatal care (numerator). Census projections or in some cases vital registration data are used to provide the denominator (numbers of live births).

• Methods of estimation: Empirical data from household surveys are used. At a global level, facility data are not used.

➢ Births attended by skilled health personnel (percentage)
• Definition: Percentage of live births attended by skilled health personnel in a given period of time.

• Data sources: Household surveys: constitute an important source of information on maternity care on an ad-hoc basis and, for many countries, they are the main source of information on births attended by skilled health personnel. When using survey data, absolute numbers and confidence intervals should be reported to indicate the reliability of the data and facilitate interpretation of trends and differentials.

• Health-services statistics: as the point of contact with women, this is the main and most obvious routine source of information for the numerator. However, health-service information cannot provide the accurate size of the denominator population. Census projections or, in some cases, vital registration data are used to provide the denominator (numbers of live births).
Methods of estimation: Empirical data from household surveys are used. At a global level, facility data are not used.

Children aged < 5 years sleeping under insecticide-treated bed nets (%)
Definition: Percentage of children under five years of age in malaria endemic areas who slept under an ITN the previous night, ITN being defined as a mosquito net that has been treated within 12 months or is a long-lasting insecticidal net (LLIN).

Malaria-risk areas include areas of stable malaria transmission (allowing the development of some level of immunity) and areas of unstable malaria transmission (seasonal and less predictable transmission impeding the development of effective immunity).

Data sources: Household surveys such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Malaria Indicator Surveys (MIS), and ‘rider’ questions on other representative population-based surveys that include questions on whether children under five years of age slept under an ITN the previous night.

Methods of estimation: Empirical data only.

Children aged < 5 years with ARI symptoms taken to facility (percentage)
Definition: Proportion of children aged 0–59 months who had ‘presumed pneumonia’ (ARI) in the last 2 weeks and were taken to an appropriate health-care provider.

Strictly speaking, ‘ARI’ stands for ‘acute respiratory infection’. During the UNICEF/WHO Meeting on Child Survival Survey-based Indicators, held in New York, 17–18 June 2004, it was recommended that ARI be described as ‘presumed pneumonia’ to better reflect probable cause and the recommended interventions. The definition of ARI used in the Multiple Indicator Cluster Surveys (MICS) was chosen by the group and is based on mothers’ perceptions of a child who has a cough, is breathing faster than usual with short, quick breaths or is having difficulty breathing, excluding children that had only a blocked nose.

Appropriate health-care provider
Definition: the definition of ‘appropriate’ care provider varies between countries.

Data sources: Household surveys such as DHS and MICS.
• **Methods of estimation**: Empirical data.

➢ **Children < 5 years with diarrhoea receiving oral rehydration therapy**
  • **Definition**: Proportion of children aged 0-59 months who had diarrhoea in the last 2 weeks and were treated with oral rehydration salts or an appropriate household solution (ORT).

  • **Diarrhoea**: according to DHS, the term(s) used for diarrhoea should encompass the expressions used for all forms of diarrhoea, including bloody stools (consistent with dysentery), watery stools, etc. It encompasses the mother’s definition as well as the ‘local term(s)’.

  • **Treatment**: child received an electrolyte solution.

  • **Appropriate household solution**: definition may vary between countries.

  • **Data sources**: Household surveys such as DHS and MICS.

  • **Methods of estimation**: Empirical data.

➢ **Children aged < 5 years with fever who received treatment with any antimalarial (percentage)**
  • **Definition**: Percentage of the population in malaria-risk areas aged less than 5 years with fever being treated with effective antimalarial drugs.

  • **Numerator (N)**: the number of children aged less than 5 years in malaria-risk areas with fever being treated with effective antimalarial drugs.

  • **Denominator (D)**: the number of children aged less than 5 years in malaria-risk areas.

  • **Malaria-risk includes areas where malaria transmission is stable (or endemic, allowing the development of some level of immunity) and areas where malaria transmission is unstable (or epidemic, as seasonal and less predictable transmission impedes the development of effective immunity).**

  • **Data sources**: Household surveys such as DHS, MICS, Malaria Indicator Surveys (MIS), and ‘rider’ questions on other representative population-based surveys that include questions on whether children aged less than 5 years slept under an ITN the previous night.
• **Methods of estimation:** For prevention, the indicator is calculated as the percentage of children aged less than 5 years who received effective antimalarial drugs during a fever episode. The information is obtained directly from household surveys. The empirical values are reported directly without further estimation.

➢ **Children 6-59 months who received vitamin A supplementation (percentage)**
  • **Definition:** Proportion of children aged 6-59 months who received a high-dose vitamin A supplement within the last 6 months.

  • **High dose vitamin A:** The International Vitamin A Consultative Group (IVACG) definition is: "doses equal or greater than 25 000 IU"

  • **Data sources:** Household surveys such as DHS and MICS.

  • **Methods of estimation:** Empirical data.

➢ **Births by Caesarean section (percentage)**
  • **Definition:** Percentage of births by caesarean section among all live births in a given time period.

  • **Data sources:** Household surveys: birth history—detailed questions on the last-born child or all children a woman has given birth to during a given period preceding the survey (usually 3 to 5 years), including characteristics of the birth(s). The number of live births to women surveyed provides the denominator.

  • **Routine health-service statistics:** the number of women having given birth by caesarean section (numerator). Census projections or, in some cases, vital registration data can be used to provide the denominator (numbers of live births).

  • **Methods of estimation:** Empirical data from household surveys are used.

➢ **Children aged < 5 years; Low-birthweight newborns (percentage)**

➢ **Stunted for age (percentage)**

➢ **Underweight for age (percentage)**

➢ **Overweight for age (percentage)**
  • **Definition:** Percentage of underweight (weight-for-age less than -2 standard
deviations (SD) of the WHO Child Growth Standards median) among children aged less than 5 years.

- Percentage of stunting (height-for-age less than -2 SD of the WHO Child Growth Standards median) among children aged less than 5 years.

- Percentage of overweight (weight-for-height greater than +2 SD of the WHO Child Growth Standards median) among children aged less than 5 years.

- Severe underweight and stunting are defined as less than -3 standard deviations of the weight-for-age and height-for-age WHO Child Growth Standards median, respectively.

- Data sources: National household surveys, subnational nutritional surveys and national nutrition surveillance systems.

- Methods of estimation: A well-established methodology for the compilation and standardized analysis of nutritional surveys, as well as robust methods for deriving global and regional trends and forecasting future trends, have been published (de Onis & Blössner, 2003; de Onis et al., 2004a, 2004b).

Special Projects, Reports and Initiatives

Monitoring children's well-being

The International Society for Child Indicators (ISCI) was established in 2005 with support from Childwatch International. ISCI aims at bringing together experts in the area of child well-being to share knowledge, consolidate information, initiate research collaboration, and strengthen research on indicators in parts of the world where such indicators have not yet been developed.

Childwatch support for activities related to monitoring children's well-being and developing child rights indicators is partly a continuation of the former Childwatch project on identifying indicators to monitor the implementation of the Convention.
on the Rights of the Child. Childwatch has also supported the multi-national project on monitoring children's well-being, which has developed a database on well-being indicators, based at the Chapin Hall Centre for Children at the University of Chicago, USA.

Several sub-groups with different geographic foci have been involved in indicator related activities within the Childwatch network. A resource group stemming from the Multi-National project at Chapin Hall was supported by Childwatch International to organize a session at the Childhoods Oslo 2005 conference in Oslo, July 2005 and to support the regional groups.

The multi-national project on indicators of children's well-being can be contacted through Asher Ben-Arieh at the Paul Baerwald School of Social Work and Social Welfare at the Hebrew University of Jerusalem, Israel: benarieh@cc.huji.ac.il

The Childwatch International regional network on Indicators of children’s well-being in Central and Eastern Europe stems from the partnership between the Key Institutions at Clemson University, USA: Institute on Family and Neighborhood Life, and in Prague, the Czech Republic: Center for Family Environments (2000 - 2003). Regional seminars have been organized in Bratislava, by the Bratislava Centre for Work and Family Studies in 2002, and by Maria Herzog at the institute for criminology in Budapest, Hungary in 2003.

A forum discussion with the Central and Eastern European network partners was held at the Childhoods 2005 Oslo conference, under the title: Childwatch networking in Central and Eastern Europe: From Bratislava to Budapest: Progress in Creating a Network of Child Researchers in Eastern and Central Europe. The discussion was organized as a follow up of the papers presented by Erika Kvapilova, Lenka Sulova and Zoran Pavlovic on multi-national efforts to measure and monitor children's well being.

The coordinators of the Central and Eastern Europe group are:
- Mark Small of Clemson University, USA
  msmall@clemson.edu
- Hana Pazlarova of the Centre for Family Environments, Prague, Czech Rep.
  hana.pazlarova@c-mail.cz
- Erika Kvapilova of UNIFEM, Bratislava, Slovenia
  erika.kvapilova@undp.org

The Key Institution at the University of Western Cape organized a conference and a technical meeting on the issue of indicators of children's well-being in 2004, supported by Childwatch International. The South Africa initiative is being
followed up by a collaborative project between the Childwatch Key Institution in Sydney, Australia, the Social Justice and Social Change Research Centre at the University of Western Sydney.

The contact for the South African initiative is Dr. Rose September of the Children and Youth Training Programme.

**Child Indicators Research**

(The official Journal of the International Society of Child Indicators  
Editor-in-Chief: Asher Ben-Arieh)

Child Indicators Research is an international, peer-reviewed quarterly journal that focuses on measurements and indicators of children's well-being, and their usage within multiple domains in diverse cultures. The Journal presents measures and data resources, analysis of the data, exploration of theoretical issues, and information about the status of children, as well as the implementation of this information in policy and practice. It explores how child indicators can be used to improve the development and well-being of children.

Child Indicators Research provides a unique, applied perspective, by presenting a variety of analytical models, different perspectives, and a range of social policy regimes. The Journal breaks through the current ‘isolation’ of academicians, researchers and practitioners and serves as a ‘natural habitat’ for anyone interested in child indicators. Unique and exclusive, the Journal is a source of high quality, policy impact and rigorous scientific papers.
GLOBAL SPECIAL PROJECTS
EARNEST, the Early Nutrition Programming Project

The project is an international EU collaboration comprising researchers from 38 institutions in 16 European countries. With a broad approach, EARNEST is attempting to discover the long-term effects of early nutrition to illness later in life. The EU is financing the project with a contribution of 13 million Euro.

In Norway, EARNEST is a subproject of MoBa (see below under Norway) and will be utilizing data from the study. Professor Per Magnus from the Norwegian Institute of Public Health is in charge of Norway’s contribution to EARNEST. He will investigate the relationship between genes, fetal growth and risk of illness in adults.

Data from the MoBa cohort of 100,000 pregnant women, their partners and children is the foundation for the research in EARNEST. MoBa participants fill in detailed questionnaires from conception onward, including data on the mother’s nutritional habits. This information will be linked with other data from the MoBa contributors, e.g. blood samples, urine samples, DNA samples and data from ultrasound examinations. Ultrasound provides data on fetal size, which can be compared to newborn weight.

Professor Magnus states that by linking the data from MoBa the group will be able to state what is attributable to genes versus the environment. They will study different subgroups of the 100,000 pregnant women. For example, they will compare the infants with particularly low birth weights to high birth weights. Low birth weight is defined as 2,500 grams or less, while high birth weight is above 4,500 grams.

EARNEST uses a broad and multi-disciplinary approach to find out what kind of long-term consequences early nutrition may have on later illness.

The studies aims are to:

- Discover the connection between early nutrition and later cardiovascular disease risk, diabetes, immunodefense, allergies, bone mineral health, cognitive capacity and cancer
- Identify critical periods for the development later life illnesses
- Examine the role of genes
- Understand the roles played by particular kinds of food, and the contribution of the mother’s nutritional habits
• Develop new strategies for treatment and prevention

• Examine the connection between people’s knowledge of nutrition and how this knowledge influences behaviour

• Examine the economic consequences of introducing programs in early nutrition

Professor Berthold Koletzko at the Children’s Hospital at the University of Munich is in charge of the entire project, from 2005 to 2010.
The EU25 child well-being index

In an article on the development of an index of child well-being for the European Union (EU25), Bradshaw, Hoelscher and Richardson1 state that while some individual member states have strong programs for monitoring child well-being; there are as yet no processes for doing so across the EU. They note as an example that the Laeken Primary and Secondary Indicators (see below) include only one related to children (“proportion of children under 16 living in households with equivalent income before housing costs less than 60% of the median and using the modified OECD equivalence scale” p. 133). They call for the EU to “raise their standards and improve the monitoring of child well-being” p. 134. These authors applaud the child rights based approach of the UN Convention on the Rights of the Child (CRC) and the empirical approach to the subjective well-being of children pioneered by Land in the US. The emphasis of the child-rights approach is on positive child outcomes. Their index is data driven. They used two main types of sources of information that were available on child well-being: sample surveys and indicators of various kinds collected routinely by international organizations; this resulted in 627 indicators relevant to child well-being. Their method was to first organize these into clusters and then select those most promising to represent domains within the clusters. In other words, wherever possible they used the child as the unit of analysis and the most up to date indicator for a country. An indicator was only used if it was available for 70% of a country’s population—Malta, Cyprus, Luxembourg and the Slovak Republic fell below that response rate.

The EU25 child well-being index: 51 indicators/variables covering 23 domains and summarized into -8 clusters including indicators that represent children’s own experiences as expressed in surveys with young people.

The eight clusters are:

1. Material situation. - These variables can only be relevant if the age of children in the household is available. This is likely to vary by country.
   a. Child income poverty. Disagreement as to how this should be represented based on limitations of income data, relative thresholds, comparability of scales and units of analysis (see Bradshaw, 2006). Ideally these authors propose a range of measures including relative child poverty rate, absolute child poverty rate, poverty gaps for children, persistent poverty for children and a subjective poverty measure.

In actual fact only relative child poverty rate and the average poverty

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gap (average gap between incomes of households below poverty threshold and poverty threshold – but note threshold problem across countries). Across the EU these variables correlate with $r = .7$ so there are combined into a single index. These figures are all in terms of children less than 16 years living in households.

b. Deprivation (correlates with levels of children in poverty $r = .5$). No indices that tap life of young children directly.
Three indices: Percentage of Children Reporting Low Family Affluence- based on self-report of the HBSC Family Affluence Scale - survey data; Percentage of Children Reporting Less than Six Educational Possessions - Based on the % of children aged 15 with less than 6 our of 8 educational items on the PISA; Percentage of children reporting less than ten books in the home - Also reported from the PISA.

c. Workless families: Children aged 0-17 living in jobless households: share of persons aged 0-17. (Source: Eurostat).

2. Housing. - Living conditions and housing
   a. Rooms Per Person in Households with Children;
   
   b. Quality of the Local Environment - from the EQLS (survey data)
      i. Percentage of households with children that think it is unsafe or very unsafe to walk around in their area at night.
      ii. Percentage of households with children under 15 scoring six or more on a scale of physical environment problems.

c. Housing Problems
   i. Percentage of households with children under 15 reporting at least two housing problems - from the EQLS

3. Health. Only the first two are relevant to children 0-5 and contain population data. There are no significant inter-correlations between these three health indices.
   a. Health at Birth: to obtain the health from birth domain they combine two variables - infant mortality rates (source: World Bank), and rate of low birth-weight (source: OECD). No weighting is used because of the absence of any theoretical or empirical justification for weighting.  

   b. Immunization: Evidence suggests this is linked to family social status

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2 While this might be established by using a scalability test (Cronbach’s $\alpha$) or by using FA to establish underlying domain, they argue that the are using a causal indicator model rather than an effect model – in which the indicators determine the domain rather than the reverse. They use sensitivity analysis of the domains and clusters to explore whether the results are the way in which variables should be combined.
but recently negative publicity – particularly the MMR – in some EU countries threatens the health of children.

i. Measles; DPT3 (final dose), Pol3 (final Polio does) (source: World Bank). Correlations reported are Measles – DPT3, \( r = 0.71 \); Polio-measles \( r = 0.63 \).

c. Health Behavior: these variables are taken from the HBSC data and are therefore based on survey. They include young people who: brush teeth more than once a day; eat fruit daily; eat breakfast daily; Mean number of day physically active; overweight according to BMI.

4. Subjective well-being. There is a significant correlation between self-defined health and personal well-being of \( r = 0.57 \).

a. Self-defined health. The HBSC survey ratings of young people 11-15 on their own health.

b. Person well-being combines four self-rated variables for young people: life satisfaction; feeling like an outsider or left out; feeling awkward or out of place; feeling lonely. (HBSC variables)

c. Well-being at School. (HBSC variables). Self-rated youth feeling pressured at school; youth liking of school.

5. Education.

a. Educational attainment- These variables are derived from reading, mathematics and science literacy data from the PISA survey.

b. Participation in childcare: Children aged 0-2 in registered childcare. This is OECD data and is a limited indicator of preschool participation in childcare because it does not cover the provision of childcare and nursery education for the important pre-statutory school entry years.

c. Post-compulsory education - Percentage of 15-19 year olds in education-OECD.


6. Children’s relationships. These are based on family or youth data - all survey data.

a. Family structure: Two variables correlate \( r = 0.8 \).

   i. Single parent families (HBSC).

   ii. Step families (HBSC).

b. Relationships with parents: There is very little comparative data on
the quality of children’s relationship with their parents available. Therefore use proxy indicators:
   i. Eating family meals around a table several time a week (OECD/PISA)
   ii. Talking with parents several time a week (OECD/PISA)

c. Relationships with peers:
   i. Young people finding peers kind and helpful (HBSC)

7. Civic participation. This domain is from Civic Education Study a survey done in 1999 and published in 2005. It includes young people’s participation in two or more civic activities (young people reporting above the median on political interest). The two items correlate r=.46 but is NS.

8. Risk and safety. Child morality and experience of violence are significantly correlated, r=.62).
   a. Child mortality is the most basic indicator of child safety. The authors combine data from the WHO Mortality Database which includes accidental deaths, murders, suicide, and deaths with undetermined cause; use averages for the three most recent years available because of reliability issues for this data. The age range is for children under 19 years of age.

   b. Risky behaviors combine data for 15 year olds from the ESPAD, World Bank and HBSC. This includes cigarette smoking, drunkenness, cannabis, inhalants, pregnancy rates, sexual intercourse, and condom use.

   c. Experiences of violence within peer group. (HBSC), Young people involved in physical fighting in last 12 months; young people who were bullied last 12 months.

   Two methods are used by authors for comparative analysis; Rank variables for countries followed by the mean rank. Calculate z scores for each indicator and average the z scores to obtain an average score for a domain. Cluster scores were then the average domain z the averages of the cluster z scores were used to create the overall index score. The advantage over rank scores was that z scores not only take account of rank order but also the degree of dispersion.

Data Sources for The EU25 child well-being index

- HBSC 2001/2002
- EQLS 2003
- ESPAD 2005
- WHO 2005: www3.who.int/whosis/menu.cfm?path=whosis,mort&language=english
- IEA/CIVED 2005: www.iea.nl/cived_datasets.html
ELSPAC is a prospective longitudinal study which is taking place in several European countries. The study aims to observe a chosen set of children and their families from the pregnancy of the mother, delivery, confinement and infancy until child is at least 18 years of age with the aim of identifying those factors which influence the healthy development of children, prospectively and to identify factors that threaten healthy development.

The study was initiated by the World Health Organization, European Office in Copenhagen. International coordinator of the study is Prof. Jean Golding from the Institute of Child Health University of Bristol in Great Britain.

Countries participating on the project include: Great Britain, Isle of Man, Czech Republic, Slovakia, Russia, Ukraine, partly Croatia and Estonia and in the beginning also Spain and Greece.

In the Czech Republic, the study is being conducted by workers in the Department of Preventive and Social Pediatrics of the Institute of Social Medicine and Public Health in the Medical Faculty, of Masaryk University in Brno. Dr. Lubomír Kukla, CSc., is the member of the Coordination and Executive Committee of the project and head of the project for countries of Central and East Europe. He is also consultant of WHO for CR. At present, the project is financed from grant support, mainly through IGA MH CR.

ELSPAC is the first study which starts from pregnancy and observes the development of children during their whole childhood and adolescence. Mothers and fathers are included in the research which assesses their personalities, behaviours, attitudes, health status, etc. ELSPAC is international project with common methodology and data collection allowing for comparisons of results among different participating countries.

The main aim of the study is to detect biological, psychological, and social factors as well as factors of the external environment, which are connected with survival and health of the fetus, newborn, infant and child. A second aim of the study is to find out bio-psycho-social determinants of a child's development from conception until the end of school age, considering the family (life style, environment, care, relationships among family members and so on) and personalities of mother and father. Lastly, the aim is to try to find the connections between bio-psycho-social determinants and genesis and development of health disorders of fetus, newborn, and child.
Domains of Study:

1. Health: subjective assessment of mother in 6 and 18 months, 3, 5, 7, 11, 15 years
2. Growth: weight, height, length of long bones, head, waist, arm circumference, skin folders and other anthropometric data
3. Development: developmental landmarks, motor coordination, intellectual abilities
4. Behaviour: social behaviour, deviant behaviour, enuresis nocturna, temperament
5. Biology: characteristics of the child including congenital genetic malformations, genetics, skillfulness
6. Morbidity: assessed by district pediatrician’s and by other specialists, including hospitalizations
7. Accidents, injuries: considers history, what happened, the concrete type of injury, first aid, way of solving the problem and treatment
8. Sensual disorders, speech disorders etc.
10. Specific termination of pregnancy: preterm delivery, intrauterine growth retardation of fetus, abortions, child of diabetic mother and so on
11. Newborn morbidity: asphyxia, hypoxy etc.

Measures
Studied areas are from different developmental stages analyzed in association with following variables:

1. Physical environment: habitation, household equipment, type of heating etc.
2. Characteristics of parents: age, height, weight, anamnesis of family members
3. Social factors: family size, social class, education of parents, incomplete family, changes of partners
4. Psychological factors: personality, depressions, anxiety, stress
5. Psychosocial environment: social support, wedded relationship, relationships among the siblings
6. Health care: paediatric, gynaecologic - during the mother’s pregnancy, care of different specialists - according to the health status of the child
7. Attitudes: mother towards child, her partner, partner’s attitude towards child, his partner
8. Environmental changes during the first months of life (moving, separation from mother, separation from father, using of preschool facilities or of another type of care of the child)

Methods
Basic research data are collected via questionnaires, which are filled out by parents of target children in the designated age levels (half of pregnancy, 6 weeks after delivery, 6 and 18 months, 3, 5, 7, 11 and 15 years of the child's age). Data about the health status of the child, about his/her development, morbidity, treatment and so on are obtained form health documentation of pediatricians consistently in charge.

Questionnaires are made in order to be suitable for every participating country. The meaning and structure of individual items are obligatory for member countries.

The data from questionnaires are coded and entered onto a computer. The owner of each national database is the participating nation. The lead study team from each country, and the International Coordination and Executive Committee of ELSPAC have the responsibility for preservation and accessibility of the national databases.

All obtained data are strictly confidential and are never distributed to individuals or institutions. They are published without the possibility of identifying individuals and families.

Within the years 2004-2005, a third investigation of children at the age of 13 took place. This pilot study ran during September and October 2005.

Example of Holdings
In the Czech Republic, the research set contains all children with permanent habitation in the town of Brno, born from 1.3. in 1991 to 30.6. in 1992 (5000 families) and children with permanent habitation in Znojmo district born from 1.4. in 1991 to 30.6. in 1992 (1500 families). Internationally - around 40,000 children are observed across the participating countries.
Luxembourg Income Study

www.lisproject.org/publications/fampol/fampolaccess.htm

LIS is a non-profit cooperative research project with a membership that includes 30 countries on four continents: Europe, America, Asia and Oceania. The LIS project began in 1983 under the joint sponsorship of the government of the Grand Duchy of Luxembourg and the Centre for Population, Poverty and Policy Studies (CEPS). The project is mainly funded by the national science and social science research foundations of its member countries. Recently, LIS and the University of Luxembourg became partners, with offices being provided by the University.

Over the years, the LIS project has expanded very quickly. The number of member countries continues to grow and the database now covers 30 countries with datasets that span up to three decades. LIS welcomes new countries whether they have advanced market economies, economies in transition, or are developing - as long as they can provide good quality household surveys. The main objective is to construct a harmonized database that can be considered as the best source for international comparative studies. Over the next several years, the plan is to expand beyond the traditional focus on high income countries to include several middle income countries.

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Databases Under LIS:

1. Household Income Surveys.
   These surveys provide income, demographic, labour market and expenditure information on three different levels: household, person and child.

2. The LIS Institutional Database
   The LIS Institutional Database (IDB) describes the tax and transfer programs of the different LIS countries and includes information on the important features of these programs (eligibility conditions, benefits, financing, provisions for dependents/survivors, indexing, etc.) as well as a number of demographic (age, immigration, ethnicity etc.), labor market characteristics, household characteristics (age of youngest child, expenditure variables, income variables, labour market variables, etc.).
   www.lisproject.org/techdoc.htm

3. Comparative Welfare States Data Set

   In the initial stage of data collection in 1989-92, it was the intention of the project directors to collect a wide range of indicators of welfare state development, and its outcomes on an annual basis for the period 1945-89. The data for the period before 1960 proved to be far too spotty for inclusion in pooled time series analysis. For this reason, this data set begins with data for 1960. Because the project leaders were faced with limited resources in the process of updating the data to 1994, the data series for a number of variables for which data are available for the period 1990-94 were not updated. Generally, it can be said that OECD data are available for this period. However, data from the ILO’s Cost of Social Security, the single most important source for data on social expenditure, was not available beyond 1989 as of December 1997.

   This update includes the original Comparative Welfare States Data Set, and updates and additions by Stephens, Brady, and Beckfield. Several new variables were added and most variables were updated to 2000. Variables in the original data set were updated using more recent versions of the original sources, and also with some new sources. Some of the original sources are unavailable in recent years and no alternative source could be identified, so those variables were not always updated. In particular, the ILO social spending data which were the
basis for many analyses beginning in the mid-1970s has not been updated. Note that some updates of those data are available to the interested scholar at the ILO website. The sources used are listed in chronological order, with the most recent source last. Dennis Quinn, Lane Kenworthy, David Neumark, Duane Swank, and William Wascher generously provided several new variables. New variables are listed with an asterisk after the variable description and source. With the adoption of the Euro in several EU countries, users should be careful in constructing ratios and percentages. One should be certain that both the numerator and denominator are in the same currency in every year. The data sources have been inconsistent in retroactively converting entire or partial time series to the Euro currency. The Gerhard E. Lenski Chair held by John D. Stephens provided financial support for the work at the University of North Carolina.

4. The Luxembourg Wealth Study
(Includes Microdata on Household Wealth. First release in 2007).

After attending the 27th IARIW General Conference in Stockholm (August 2002), where research results on trends of wealth inequality in five countries was presented, it was obvious to Andrea Brandolini that wealth comparability was lagging far behind income comparability (data are available for fewer countries, data collection procedures differ widely and the very same definitions of the wealth components are far from being homogeneous across nations). A meeting was called to discuss the feasibility of developing the Luxembourg Wealth Study (LWS). On July 16, 2003 in Luxembourg, 22 experts on wealth and data collection participated in a meeting to explore the possibility of constructing cross-national comparable datasets from existing data, establishing a network of producers of microdata on household worth, and the production of guidelines for data producers, similar to the Canberra Handbook. In January 2005 a conference on the "Construction and Usage of Comparable Microdata on Household Wealth: the Luxembourg Wealth Study" was held in Perugia, Italy, hosted by the Bank of Italy. In July 2005 preliminary results of the harmonization of the initial datasets were analyzed and presented at the First Meeting of the Society for the Study of Economic Inequality.

In August 2006, the first results for the full set of countries were presented at the first plenary session of the IARIW Conference in Joensuu, Finland on “Issues in the Measurement of Wealth”. A short paper describing LWS has been published in the OECD Newsletter No.31 (May 2006) and in the Journal of Economic Inequality 4(3): December 2006.

The Alpha version is to be put online and available to all users of LIS sometime in 2007. The database includes a number of demographic (including age, immigration, ethnicity etc.), labor market characteristics, and household characteristics including number of children 5 and under, wealth variables (financial assets and inheritance), expenditure variables including childcare expenses, and income variables.

The LIS team harmonizes and standardizes the micro-data from the different
surveys in order to facilitate comparative research. The datasets can be accessed via the internet mailing system by submitting SAS, SPSS or STATA programs (no direct access). Interested researchers should go to the user information page.

5. Family Policy Database
LIS offers two Family Policy Databases, both constructed by Janet Gornick and her colleagues. The first database describes selected work/family policies in fourteen countries, as of the middle 1980s. The second database is an update and expansion of the first one. The later version includes characteristics of work/family policies in twelve countries, as of approximately 2000.

Data were assembled by Janet Gornick and Marcia Meyers, and were published in 2003. The data contained in Version 2 of the Family Policy Database differ from those in Version 1 in that (a) they contain additional policy areas (in particular, working time regulations); (b) they offer considerably more detail in each program area; and (c) they describe policy provisions as of approximately 2000. Version 2 also omits two countries that were included in the earlier database -- Australia and Italy -- due to data limitations. The plan is to restore these two countries and to add additional countries in future releases.

The policy data included in Version 2 are presented in Excel workbooks, each with several worksheets containing the individual tables. Each table includes citations and a full list of references is provided as well (in a separate Word file). In addition, a set of composite indexes is presented; these combine policy features across program areas, and their construction is documented.


Measure/Variables pertaining to infants and children 0-5 years of age.

Family Leave Policies
FL. Table 1: Family Leave - Maternity and Parental Leave Provisions, Approximately 2000
FL. Table 2: Leave for Family Reasons; Example: "Sick Child" Provisions, Approximately 2000
FL. Table 3: Provisions for Fathers: Paternity Leave and Incentives for Take-Up of Parental Leave, Approximately 2000
FL. Table 4: Family Leave Financing, Late 1990s
FL. Table 5: Maternity and Parental Leave Expenditures, per employed woman (2000US$ PPP-Adjusted), 1998

Early Childhood Education and Care (ECEC)
CC. Table 1: Institutional Arrangements and Entitlements for Publicly Supported Early Childhood Education and Care, Approximately 2000
CC. Table 2: Enrollment in Publicly Supported Early Childhood
Education and Care, Approximately 2000
CC. Table 3: Government Mechanisms for Financing Early Childhood Education and Care, Approximately 2000
CC. Table 4: Co-Payment Policies and Estimated Share of ECEC Costs Assumed by Government, Approximately 2000
CC. Table 5: Distribution of Parental Child Care Costs in France and the United States, Families with Employed Mother, US and France, Late 1990s
CC. Table 6: Public Spending on Early Childhood Education and Care, per Child (2000 US$ PPP-Adjusted), Middle 1990s
CC. Table 7: ECEC Quality Regulations, Approximately 2000
CC. Table 8: ECEC Staff Compensation, Approximately 2000
CC. Table 9: Hours and Days of Supervised Care, Approximately 2000

Policy Indexes
IN. Table 1: Raw Data for Indexes
IN. Table 2: Policy Indexes

The indexes were constructed as follows (see Gornick and Meyers 2003, for more detail):
1) Converted policy data presented in the detailed policy data tables to 22 indicators. Quantified data (e.g., ECEC enrollment rates) and coded qualitative data (e.g., ECEC quality) into categories (e.g., high, medium, low.)

Inclusion of all of our major policy measures, with the exception of those that regulate part-time work, as implementation of most of those measures remains ongoing. For all 22 policy indicators, coded data correspond to the data in the policy tables, with one exception. Because the current regulated work week in France (35 hours) was implemented so recently, the value that was current in France in the late 1990s was utilized. The 22 indicators include (with units):

Early Childhood Education and Care (ECEC)
v1 guaranteed slot for some children 0-1-2 (yes, no)
v2 enrollment in public care < age 1 (% of age group)
v3 enrollment in public care age 1-2 (% of age group)
v4 cost to parents if children in public care age 1-2 (% of total cost)
v5 enrollment in public care age 3-4-5 (% of age group)
v6 cost to parents if children in public care age 3-4-5 (% of total cost)
v7 typical hours age 3-4-5 (full-day, mixed, part-day)
v8 enrollment age 6 (if compulsory school at 7) (% of age group)
v9 quality (low, medium, high)
v10 tax relief for ECEC (yes, no)

School Scheduling
v11  starting age (age)
v12  hours per day (hours)
v13  days per year (days)
v14  continuity of school day (yes, no, sometimes)

Family Leave
v15  weeks of full-pay available to mothers (weeks)
v16  paid paternity leave (yes, no)
v17  gender equality scale / incentives for fathers (see below)
v18  some paid leave after 3rd birthday (yes, no)
v19  paid sick child leave (yes, no)
v20  expenditures on leave (2000 $US/employed woman)

Working Time
v21  normal weekly hours (hours)
v22  normal vacation time (days)

2) Conversion of all qualitative values to quantitative values (e.g., high, medium, low were coded as 1.0, .66, and .33.) All indicators were re-scaled such that a higher value signified more policy support. For example, cost to parents if children are in public care was converted to cost to government (for children in public care), with a higher value signifying more government support. School starting age and normal weekly work hours were converted such that higher values signify an earlier starting age and shorter weekly work hours.

3) Re-scaled all indicators so that their values ranged from 0-1 via one of the following methods: using the original value if it was a percentage (e.g., enrollment rates), dividing by the observed maximum (e.g., weekly school hours), or dividing by the theoretical maximum (e.g., the gender equality scale).

4) Creation of seven sub-indexes by combining the individual indicators. Weighted some items based on the expectation of the share of the families affected by individual components. The sub-indexes were constructed as follows.

\[
sA_{ECEC \text{ age } 0-2} = v1 + [.33v2] + [.66v3] + v4 + v9 + [.25v10]
\]

\[
sB_{Family \text{ leave age } 0-2} = v15 + v16 + v17 + v19 + v20
\]

\[
sC_{ECEC \text{ age } 3-4-5} = v5 + v6 + [1.5v7] + v9 + [.25v10]
\]

\[
sD_{Family \text{ leave age } 3-4-5} = v17 + v18 + v19
\]

\[
sE_{Family \text{ leave age } 6+} = v19
\]

\[
sF_{School \text{ schedules}} = [.10v8] + [.10v11] + v12 + v13 + v14
\]

\[
sG_{Working \text{ time}} = v21 + v22
\]

Re-scaling of these sub-indexes to 0-1 by dividing by the observed maximum.
5) Conversion of the sub-indexes into Indexes A, B, and C as follows:

Index A: all policies that affect families with children aged 0-5 = sA + sB + sC + sD + sG

Index B: all policies that affect families with children aged 6 and over = sE + sF + sG (weighted to give school schedules [sF] 50 percent)

Index C: all policies that affect families with children = sA + sB + sC + sD + sE + sF + sG

Re-scaled Indexes A, B, and C to 0-1 by dividing by the theoretical maximum (5, 3, and 7, respectively). These index values are presented in IN. Table 2.

Finally, note that variable v17 presents a “gender equality in paid family leave” scale. It was constructed as follows:

Countries assigned one point on the “gender equality scale” if they have any paid paternity leave, two points if fathers have non-transferable parental leave rights (either “use or lose” portions of shareable leave or individual entitlements) and up to three additional points depending on wage replacement (three points if benefits are wage-related and at 80 percent or higher, two points if benefits are wage-related but at less than 80 percent, and one point if benefits are paid but only at a flat rate).
Multi-National Project for Measuring/Monitoring Children’s Well-being

The Multi-National Project for Monitoring and Measuring Children’s Well-Being is an ongoing, multi-phase effort to improve our ability to measure and monitor the status of children around the globe that arose out of The Jerusalem workshop.

Phase One (1996-2000): Over 80 experts from a variety of disciplines and organizations in 28 countries worked collaboratively to redefine the concept of children's well-being, and to identify new and more appropriate indicators for measuring and monitoring the status of children beyond survival. During this phase the project was known as "Measuring and Monitoring Children’s Well-being: Beyond Survival." Five domains of children's well-being and approximately 60 indicators were identified.

Phase Two (2001-2005): Renamed as the "Multi-National Project for Monitoring and Measuring Children’s Well-Being," the objectives are fourfold:

1. To identify indicator measures and build a reliable and valid scientific protocol for collecting new data on children's well-being.
2. To build a collaborative multi-national network of partners and local researchers who use this protocol to study children's well-being.
3. To develop an archive of the data collected in the national and local studies.
4. To build a strategic plan for disseminating the knowledge gained from the studies, and to build partnerships with potential users of the data — professionals, policy-makers, advocates, communities, children and youth.

Phase Two of the project is a collaborative effort of four institutions from three different countries. Planning grants were received from the W.T. Grant foundation and the Federal Inter-agency forum on child statistics in the USA.

The website provides information on the rationale for the project, the history of Phase 1 and the domains and indicators identified. Additionally, it contains information on the measures identified for the indicators during Phase 2. It serves as a tool for anyone interested in measuring and monitoring children’s well-being.

The group emphasizes that these measures are still in progress. To obtain additional details, contact the project coordinators:

Dr. Asher Ben-Arieh abenari@CLEMSON.EDU
Dr. Robert M. Goerge.

The project relies on a number of concepts in selecting the various domains of
child well-being. The group took into consideration the values they wanted to stress, the desire to remain policy relevant, their understanding of the changes occurring in the field of social indicators, and their concern with the whole child. In addition, they have attempted to remain culturally sensitive. While they have concentrated their work on five domains of children’s well-being, they acknowledge these five domains may not provide a definitive categorization for some research objectives, and that they may not be the only or even the most important. These are bolded below in larger typeface with the relevant subdomains in smaller typeface and bolded.

The indicators that pertain to (or include) children 0-5 are listed below under the measure category wherever they pertain to children 0-5. To date, there is only data for those that are gathered administratively. The other listed indicators are meant to provide a list of suitable indicators for participating countries to use in monitoring child well-being.

Safety and Physical Status
The safety and physical status domain addresses the most basic components of well being, whether a child is and feels safe from physical injury and trauma or is affected by physical or environmental threats, and the extent to which the child leads a physically healthy lifestyle. Below those that pertain to children 0-5 are bolded. Not all indicators have measures.

Subdomain: Safety

Received Parenting Practices

Prevalence of Child Abuse and Neglect

Perceived Safety vs. Risk

Exposure to Environmental Hazards

Physical/Neighborhood Crime
Things I Have Seen and Heard: Measure exposure to violence and victimization in the home, at school, and in the community

• Respondent(s): Ages 5-7

Exposure to War and Terrorism
Childhood War Trauma Questionnaire Youngest age 5.
Child Behavior Inventory Youngest age 5.

Rate of Injury or Trauma
World Health Organization’s mortality database
- Source: World Health Organization
- Author(s): World Health Organization
- Type of Measure: Administrative Data

Subdomain: Physical Status

**Height, Weight and Body Mass Index**
Global Database on Childhood Growth and Malnutrition
- Source: [www.who.int/nutgrowthdb/](http://www.who.int/nutgrowthdb/)
- Author(s): World Health Organization
- Respondent(s): Ages 0-5

**Level and Incidence of Physical Activity**

**Eating Habits and Diet**
National Diet and Nutrition Survey
- Respondent(s): Ages 4-18

**Personal Life**
This domain includes measures of a child's ability to initiate and maintain social interactions, the extent and level of self-esteem, self-efficacy, and other emotional capacities, and culturally relevant measures of educational achievement and work-related skills.

Subdomain: Interpersonal Skills and Resources

**Support from Family, Friends, and Others**

**Conflict Resolution Skills**
Home Interview: Hostile Attribution Biases: Attribution of hostile intent in ambiguous situations
- Author(s): Dahlberg, L.L., Toal, S.B., and Behrens, C.B. (1996)
- Respondent(s): Ages 5-13

**Social Communication Skills**

**Behavior Among and With Peer Group**
Child Behavior Checklist: Measure’s child’s behavioral problems
Behavior Checklist/4-18 and 1991 Profile. Burlington, VT: University of Vermont, Department of Psychiatry
- Author(s): Achenbach, T.M. (1991)
- Respondent(s): Parents and teachers of children ages 4-18
- Countries Used In: Australia, Chile, Holland
- Languages: Has been used internationally in Australia, Chile, Holland, Puerto Rico, Thailand and others. The CBCL is available in 33 languages (Achenbach, 1991b)

Social Skills Rating System: Measures social skills
- Author(s): Gresham, F. and Elliot, S. (1990)
- Respondent(s): Children ages 5-18

Strengths and Difficulties Questionnaire - Parent/Teacher: Attributes of children’s behavior
- Author(s): Goodman, R. (1997)
- Respondent(s): Parents and teachers of children ages 4-16
- Countries Used In: Great Britain, India
- Languages Translated Into: SDQ is offered in over 30 languages. Used in Britain (101 subjects aged 4-16 years) and in Bangladesh (89 subjects aged 4-16 years: Goodman, Renfrew, & Mullick, 2000)

Subdomain: Intrapersonal Skills and Resources
Anxiety and Depression
Child Behavior Checklist: Measure’s child’s behavioral problems
Happiness, Life Satisfaction, Well-Being, and Quality of Life
Perceived Self-Efficacy and Self-Esteem

Subdomain: Academic Skills and Resources
Literacy
Because PIRLS researchers have found that parent’s attitudes about reading (from the parent study) and children’s reading habits (student study) each correlate strongly with the child’s literacy achievement, questions were included in PIRLS that measure parent’s attitudes about
reading (having positive attitudes about reading), children's reading habits (choosing reading for recreation, reading for knowledge and information, discussing one's reading both orally and in writing) and it is suggested that these questions might be used as proxies for literacy achievement.

Other research suggests additional important correlates of literacy achievement, include:

1. Reading aloud to children by parents/adults
2. Encouraging children to engage with the pictures in the books
3. Writing letters or names encourages children to develop an awareness of text
4. Children playing with books and other printed material may also encourage a foundation in literacy
5. Home resources: available printed material and educational resources
6. Home-school connection: students who discuss their reading material or school work with parents/guardians are higher achievers than those who do not
7. Out-of-school literacy activities: reading for fun or to investigate topics of interests in books or via the Internet
8. There may be a negative correlation between time spent watching TV and reading achievement

Released items from PIRLS, PISA and TIMSS were reviewed and questions measuring these correlates were extracted.

Civic Life
Indicators in this domain measure the extent to which children have opportunities to engage in civic and community activities; and the level to which children are exposed to and trust government; their knowledge of the fundamental principles of democracy; recognition of international issues and organizations; and belief in civil rights and opportunities for all.

The measures identified in this domain come exclusively from the Civic Education Study (CIVED) developed by the International Association for the Evaluation of Educational Achievement (IEA). The CIVED measures 14-year old students' civic knowledge, skills and attitudes across the following three domains: democracy, national identity and international relations, and social cohesion and diversity. The survey was conducted in 1999 in 28 countries. Judith Torney-Purta, Coordinator of
the CIVED, University of Maryland and a participant in Phases I and II of the Multinational Indicators project guided the selection of the measures included in this domain, and gave permission for their inclusion in this study and database. Users of this database can choose among the measures/questions identified and the examples included can be adjusted to include college in industrialized countries. For the CIVED report and full instrument see www.wam.umd.edu/~iea

**Children’s Economic Resources and Contribution**

The impact of economic conditions on children cannot be ignored. Economic resources available for children play a critical role in enabling them to enjoy life as well as to develop. But children are not merely an economic burden on society (or the family). Children are also an economic resource, active actors, and contributors within their households or societal economies. Indicators in this domain focus on the objective and subjective economic status of children. All measures, references and data sources in this domain were identified by Professor Jonathan Bradshaw, University of York, UK.

**Children’s Activities**

Across political jurisdictions and cultures, children engage in work, play, creative activities, consumption, social interactions, and other activities that are analogous to adult activities yet qualitatively different. Children are active in their families, among peers and community groups; in various social institutions and settings, such as schools, informal educational programs and institutions, and recreation facilities; as consumers and as users and creators of information networks and other media. Indicators in this domain are related to how children divide their time across different activities, the nature of the activities, places in which these activities occur, and children’s perceptions of the relative importance and contribution of the different activities to their lives.

**Subdomain: Children’s Activities**

**Time Use - Activities**

**Where is Time Spent**

**Time Spent with Parents**
In September 1997, the Organization for Economic Cooperation and Development (OECD) and UNESCO established the World Education Indicators (WEI) Project, with the support of The World Bank. The primary aim of the project is to develop a small but critical mass of policy-oriented education indicators that measure the current state of education in an internationally valid and comparable manner. The indicator framework established by OECD for the Indicators of National Education Systems (INES) Project is being used as the basis for indicators in the WEI project. These indicators cover the population from 5 to 65 years.

In particular, the report enables the 19 countries participating in the WEI program to compare their educational outcomes to those of countries in the OECD. It is therefore being released in parallel to the Education at a Glance series, which provides similar data for OECD Member States.

Participating countries are: Argentina, Brazil, Chile, China, Egypt, India, Indonesia, Jamaica, Jordan, Malaysia, Paraguay, Peru, the Philippines, the Russian Federation, Sri Lanka, Thailand, Tunisia, Uruguay and Zimbabwe.
A number of European countries do not have available English databases. Most European countries do have data available through Eurostat and other global databases. Attempts were made to find country-specific data on the following countries, however no English databases were available: Belgium, Bulgaria, Cyprus, Estonia, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania, Slovakia, Slovenia.
Description of Database

Statistics Austria is an information centre serving citizens, companies, academia, policy-makers, administrators, and international institutions (in particular the European Union). Its aim is to provide a comprehensive, objective picture of Austria’s economy and society. Education data is available for school-aged children. The English version of their homepage is under redesign and will be available shortly.

INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics


➢ Census data [Volkszählung 2001 Textband (Standardpublikationen)] is collected on the population by age (0-4 years of age), sex and place of birth.
  • Other population data such as by citizenship, place of birth, religion, education and occupation is either grouped “up to 14 years of age” or 15 years and up.
Czech Republic
Czech Statistical Office

www.czso.cz/eng/redakce.nsf/i/home

Description of Database

This office collects a wide variety of data on the population in large part census type data, data on the economy, the labour market, agriculture, etc. Included for 2007 are the following statistics relative to young children ages 0-5.

INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

➢ Number of live births.
➢ Total fertility rate of woman in childbearing age.
➢ Age of mothers and age of mothers at first birth.
➢ Children born to mothers from birth cohorts including the first child born to mothers of a generation.
➢ Children born outside marriage - live births born outside marriage and whether it is a first birth.
➢ Level of education of mother
➢ Since 2007, the characteristics of the father are recorded not only for marital births but also for non-marital births including age of fathers.

Special Projects, Reports and Initiatives

Centre for Family Environments

The Centre for Family Environments (Director: Jiri Kovarik) has interdisciplinary permanent staff representing researchers and professionals in psychology, sociology, education and social work. In addition, the centre also has a wide number of associates representing medicine, law, public relations and others who
co-operate in various projects.

The centre has a wide range of programs aimed at finding new families for handicapped and abandoned children; helping new families cope with psycho-social problems; providing psychological and social services for foster and adoptive families in need; informing the public about adoption and foster care; cooperating internationally to assess possibility of international adoption of children from the Czech Republic; developing a model of complex professional services for families in the Czech Republic; developing programs for Roma children and families; and art-therapeutic activities with children in institutions. In addition the centre carries out research on children growing up in family and non-family environments and monitors the state of children (in collaboration with other institutions) and children’s rights.

Institute for Information on Education


This institute engages in the following: administration and development of the overall database (i.e. regular data-collecting from sector statistics and information system and other data sources); administration and development of standardized tools (codebooks and registers); complex data service to the Ministry of Education, Youth and Sports, public authorities, education administration, administrative organizations and to the professional and uninitiated public; cooperation with international organizations dealing with education issues, education and training systems and statistics in education (OECD, EU, UNESCO); conceptions and strategies for informational and presentation outputs from its database; and representation as the INES national coordinator and a member of the INES Technical Group and Networks.
Denmark

Demographics and Vital Statistics: www.dst.dk
Health: www.dst.dk/HomeUK/Guide.aspx

Description of Databases

StatBank Denmark contains detailed statistical information on the Danish society. The database is free of charge and data can be exported in several file formats and presented as diagrams or maps. Everybody has free direct access to StatBank Denmark. You can access StatBank Denmark without having a user profile. Making a user profile in StatBank Denmark is free of charge. A major advantage of having a user profile is the possibility of extracting tables with up to 100,000 figures. Non-profile users can only extract tables containing up to 1,000 figures or data cells.

Social Services Information

Together with employment and education policy, social and health policy form the cornerstones of the Danish welfare system. Social benefits and health care are generally offered free to citizens and are largely tax funded. Therefore, population data on these areas covered by public expenditures would be collected, although not all are in English or available publicly through the website.

The Ministry of Social Affairs is in charge of day-care facilities (dagtilbud) for children, while school facilities fall under the responsibility of the Ministry of Education. The Danish Institute for Educational Research is the sector research institute of the Ministry of Education. The Institute carries out research concerning educational problem complexes relating to young children, school start and school-based after-school activities. The Royal Danish School of Educational Studies is in charge of the research and data collation carried out by the Centre for Research concerning Young Children in the field of early childhood education and care policy (EDEC).

Day-Care For Children. Support for families with children and young people is made up mainly of social services. For families with children, the main benefit is public child-care. Child-care, in the form of crèches for 0-3 year olds and nurseries for 3-6 year olds is provided by the local authorities. Many authorities have introduced a care guarantee, which means that parents are guaranteed a day-care place for the child after its first birthday. The aim of child day-care is partly to contribute to the children’s development and partly, and perhaps more importantly, to enable the parents to work.
Preschool education. (one-year preschool class)

The Folkeskole Act lays down provisions governing preschool classes (børnehaveklasse), including the following provisions:

- The folkeskole must comprise a one-year preschool class (børnehaveklasse), nine years of basic schooling and a one-year 10th form;

- The local authority is responsible for the establishment of preschool classes (børnehaveklasser);

- At the request of its parents, a child must be admitted to a preschool class (børnehaveklasse) in the calendar year of his or her sixth birthday or - under certain circumstances - one year before or one year after his or her sixth birthday;

- Teaching in preschool classes (børnehaveklasse) should insofar as possible take the form of play and other developing activities and should not be scheduled systematic training similar to conventional “school teaching”. Furthermore it should be endeavoured to make the children familiar with the daily routines of school life;

- In the preschool class and the first and second form levels, part of the teaching may be organized as an “integrated school start” (see below).

In small schools all teaching in these forms may be carried out as common activities. The percentage of working women in Denmark is among the highest in the world. Users have to pay for day-care. Their contribution can be up to 33% of the cost, but in most areas it is smaller.

The preschool class (børnehaveklasse) is part of the basic school system and similar private schools cater for children from the age of 5/6. The børnehaveklasse is the optional one-year preschool class and is the educational offer that comes closest to “Early Childhood Education”. Although the preschool class is not part of the compulsory education period, about 98% of all children attend a preschool class. This percentage has remained more or less unchanged in recent years. The statistics on enrollment, places, and teacher training were not found at any of the listed sites.

The Danish welfare system is extensive. It covers the entire population and most public expenditure goes to the welfare system. Only statistics for adoptions are found on the website but it is certain much more is collected.
INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Mother’s age at child birth
- Marital status
- Citizenship
- Place of birth and place of residence
- Live-born/stillborn, single/multiple, delivery
- Birth order, sex, weight and length
- Deaths (sex, age, place of residence, city, place of birth, cause of death and place of death)

Education and Child Care

- Number of day-care facilities
- Places, children, staff and rates relating to daycare facilities (dagtilbud) for children.
  - The figures are published in the Social Research Statistics. The Ministry of Social Affairs publishes an annual report called Social Trends - The Social Information and Analysis System.
- Enrolment (distribution by age, day clients, 24-hour clients, full-time/part-time, etc.)
- Staff (function, type of work, educational level, etc.)
- Number of children aged 0-9 enrolled in day-care facilities and SFO facilities
- Coverage rates applying to these children broken down by the following age intervals: below 3 years, 3-5 years and 6-9 years as well as intervals of one year
  - The coverage rate for children under the age of three has been calculated on the basis of the number of children aged 6 months-2 years. The unit is the institution or the municipality/county. For more information on these institutions, visit: www.dst.dk/HomeUK/Statistics/focus_on/focus_on_show.aspx?sci=13
Health

- Receivers of public health insurance by region, sex, age (0-4, 5-9) and time (All Denmark).

- Benefits
  - For example consultations with general practitioners and specialist doctors, treatments by physiotherapists and chiropractors, etc., those are settled in the joint-municipal system, which means that some of the total expenditure in the public health system is not included in the statistics (expenditures for medicine, travel insurance, private laboratories, etc.). In the statistics, certain benefits are included, although they are not included in the Act on the Public Health Service.

- Health examinations of children and pregnant women.

- Vaccinations of children.

Child Welfare

- Sex
- Age
- Country of birth of the child
- Age of adopting parents
- Type of adoption
  - Adoptions, both adoptions of a stepchild and other adoptions. The data on age and country of birth are published as grouped data.

Special Projects, Reports and Initiatives

The Ministry of Social Affairs provides support for a number of pilot projects organized by local authorities, but these are not accessible in English.

Children in care (CIC): A Danish longitudinal study

This is a longitudinal study of all Danish children born in 1995, who currently are or formerly have been placed in care. The first data collection point was conducted in the spring 2003, when the children were 7-8 years of age. The study aims to follow up with the children every third year during childhood, adolescence, and adult life. At each new data collection newcomers into care from the 1995 cohort will be included in the sample.

This a unique data set designed for analyzing the health and development of
children as well as the effects of non-institutional sources of learning and institutional welfare efforts. Data from interviews of the mothers and questionnaires administered to the fathers are now available for 1996, 1999 and 2003. This research program includes a new data collection point in 2006 to be used as an important prerequisite for analyzing the connection between children's upbringing, how they fare in the first years of school, and their score on the SDQ-scale (Strengths and Difficulties Questionnaire). And, for the first time, the children (11 years of age) will go through a 30 minutes web based interview as well as a 20 minutes test in language and logics.
Description of Databases

Statistics Finland’s free of charge statistics database (the StatFin service) was updated during 2007 to Swedish and English language content of the StatFin database. With the completed update all Statistics Finland free of charge and chargeable statistics databases (excluding the time series database Astika) uses the same PX-Web technology and the further processing of the data in different forms, for example as Excel files, is easy. Free of charge databases are a vast source for the basic data. Chargeable databases, for one, contain longer time series, analytical indicators and more detailed information of a certain topics.

Social System Information

Finnish ECEC - system
Day care is the most important area of public ECEC activities. The Finnish ECEC system consists of municipal and private services. Municipalities must offer day care in the official languages of Finland: Finnish, Swedish and Sámi. As of 1996, the parents of all children under school age have enjoyed the right to a place in day care for their child provided by their local authority. Since August 1997, it has also been possible for families to receive a private childcare allowance in order to provide their children with private care. Over 90% of day care services are municipally provided. Program content of ECEC forms an integrated entity that consistently promotes early childhood development. The content of ECEC is guided by the National Curriculum Guidelines on ECEC (2003) and the Core Curriculum for Preschool Education (2000).

Family child care allowance: After the parental leave period, families are provided with three different options until the child begins compulsory school:

1. Caring for the child at home on care leave and receiving child home care allowance (until the youngest child turns three years).
2. Having the child cared for in private daycare with the private child care allowance.
3. Having the child cared for in municipal day care.

All of these options are on the national level administered by the Ministry of Social Affairs and Health. On the national level, preschool education is administered by the Ministry of Education.
Staff variables: Well-educated and multi-disciplinary staff is one of the strengths of the Finnish system. The staff in day care centres is required to have at least a secondary-level degree in the field of social welfare and health care. One in three of the staff must have a post-secondary level degree (Bachelor of Education, Master of Education or Bachelor of Social Sciences). Preschool teachers are required to have either a bachelor or master’s degree in education, or a bachelor degree in social sciences with an additional pedagogical course. Family child minders must have appropriate training. In practice there is variation in the length and content of the training. In 2000 The National Board of Education presented a recommendation for a new vocational training for family child minders (Further Qualification for Child Minders, 2000).

Adult-child ratio in day care centres: The adult-child ratio in day care centres is one to seven for 3-6-year-olds and one to four for children under the age of three in full-time service. When arranging part-time service, the ratio is one to thirteen for 3-6-year-olds and one to four for children under the age of three. These ratios apply also to preschool education when provided in day care centres. When preschool education is provided in schools, the recommendation for the ratio is one to thirteen and the recommendation for the maximum group size is 20. When group size exceeds 13, the teacher must have an assistant with at least an upper secondary level training.

The adult child ratio in family day care is one to four, including the child minder’s own under school-aged children. Additionally, the child minder can provide part-time care for one preschool or school-aged child. This has gradually improved since the 1960’s. In 1964 maternity leave and allowance were granted, and in 1978 fathers got the possibility for paternity leave and allowance. The period of parental leaves is currently about 43 weeks. In addition, since 1985 parents have been able to arrange the care of their children by means of the child home care allowance. The child home care allowance can be granted immediately after the parental allowance period ends.

**INDICATORS INCLUDED IN DATABASES**

Demographics and Vital Statistics

- Live births
- Deaths, Natural increase, Intra-municipal migration by Age
- Age groups total
France

Demographics and Vital Statistics: www.cnis.fr/ind_enroute.htm
Education and Child Care: www.education.gouv.fr
Special Reports on Education: www.education.gouv.fr/cid5489/reperes-et-references-statistiques.html

Description of Databases

Some statistics and databases information is available in English but relevant population statistics are best accessed through EUROSTATS or other global database sites. Even if in French, not a great deal is directly accessible through the internet.

Census France
In January 2004, the census of France’s resident population became annual. But not everyone is enumerated the same year. A new census method replaces the traditional enumeration conducted every eight or nine years. The 1999 general population census was the last to cover the entire population simultaneously.

Municipalities with fewer than 10,000 inhabitants now carry out a comprehensive census over a five-year period. One-fifth of the total number of municipalities in this size category is surveyed each year.

Municipalities with 10,000 or more inhabitants conduct an annual survey of a sample of about 8% of their population. The data are collected in January-February (and until March in La Réunion). An enumerator leaves the schedules with households and picks them up when they have been filled out.

Education
The Ministry of education collects many statistics on the educational system. There is a reference book available for purchase through the website that provides detailed statistical information on all areas of National Education, titled Benchmarks and references statistics on the lessons, training and research. It includes text, and comments on tables, graphs and maps. More than 150 subjects are updated every year, divided into twelve chapters, one devoted to the DOM-COM and another to research in France. Some new topics are also offered each year in light of current events. In addition, benchmarks, references, statistics on the lessons, training and research are included.

There are also a number of focused reports that appear to address specific issues of interest to the Ministry. For example, the Ministry has taken up the issues of equity in the educational system and how to measure social inequalities with the aim of finding a solution. Thus they report having statistics regarding access to education and enrollment including at the kindergarten level.
Since 1989, national and mandatory assessments occur during 2\textsuperscript{nd} and 6\textsuperscript{th} grade at the beginning of the school year. These assessments are done by the teacher at one and a half months into the school year to assess strengths and weaknesses in French and Mathematics. This assessment is intended to analyze the serious difficulties faced by some students and to remedy the situation before the end of the school year. A national "diagnostic" evaluation is being tested in the classroom at first grade.

In 2001 it was proposed that an initial assessment and support for learning occur at the entrance to preschool and at the entrance to the preparatory courses in various fields. The objective is to assist teachers to the point at the beginning of the school year on skills and difficulties of their students in order to develop programming for their class by taking into account the achievements and individual needs. Whether or not this has occurred is not clear from the website information.

A bank of tools for diagnostic evaluation, from kindergarten to grade 6 in all disciplines is available to teachers on the Internet.

Website for bank of tools for evaluation: [www.banqoutils.education.gouv.fr/](http://www.banqoutils.education.gouv.fr/).

Website for evaluation statistics: [www.education.gouv.fr/pid53/evaluation-et-statistiques.html](http://www.education.gouv.fr/pid53/evaluation-et-statistiques.html)

### INDICATORS INCLUDED IN DATABASES

**Education and Child Care**

- Establishments
- Pupils at primary level
- The secondary school; Apprentices; Students
- Continuing education
- Results
- Diplomas
- Inclusion
- Staff
- Budget
- Financing costs
- Research and development

**Health**
Occupation and age of mother
Course of the pregnancy and childbirth
Weight and size
Chronic diseases
Immunization
Asthma and allergies

Special Projects, Reports and Initiatives

Le projet Étude longitudinale française depuis l’enfance ELFE

Director of GIS: Henri Leridon
Coordinator In VS: Georges Salines
Sector Coordinators:
- Social Science: Claudine Pirus
- Health and the Environment: Stephanie Vandentorren,
- Health: Corinne Wood (àtemps part)

The Scientific Council
- Christian Baudelot (D sociology, ENS, Paris)
- Anne Cambon (Geneticist Inserm U558, Toulouse), Chairman
- Chantal Cases (director IRDES, Paris), Vice President
- Sylvaine Cordier (Environment epidemiologist., INSERM U625, Rennes)
- Michel Fayol (cognitive psychologist, Univ. Clermont and CNRS)
- Denis Hémon (Environment epidemiologist. Eds. IFR69, INSERM, Villejuif)
- Juliane Leger (pediatrician, Hôp. Robert-Debré, Paris)
- Eric Maurin (economist, CNRS and EHESS, Paris)
- Joel Menard (professor of public health, CNAM, Paris)
- Heather Joshi (Demographer, head of the Millennium Cohort, London)
- Anne Nybo-Andersen (Epidemiologist, Co-Chair of the cohort Danish DNBC, Copenhagen)
- Fred Paccaud (Prof. Santépublique, IUMSP, Lausanne)
- Jenny Pronczuk (WHO Sécuritéenvironnementale children, Geneva)
- Jordy Sunyers (Epidemiologist Environment, IMIM, Barcelona)

List of clusters and Theme Leaders
- Population and Family - Didier Breton (Univ. Strasbourg)
- Economic and precariousness - Gaël de Peretti (Ensae-Cepe)
- Education and Socialization - Bertrand Geay (Univ. Amiens) and Françoise Oeuvrard (Depp)
This project takes a multidisciplinary approach with the aim put forth by The National Plan "Santé-environnement” June 2004 which proposed (Action 26) to produce an epidemiological study of children that describes the health status of children according to age, and measures their exposure to environmental pollutants, thereby analyzing the relation between exposures and health status.

The key principles are namely that some of the risk factors for disease or accidents occurring in adult health should be sought in events or specific exposures during childhood (or during pregnancy), and that genetic predispositions or otherwise of equal social and family factors can play a significant role. In this approach, the problems of timing and interaction are essential. It is therefore deemed important to create accurate biographies.

Early in 2006, large institutions (Inserm, INED, Insee, Invs) and authorities most concerned (Drees, Education, Health, etc.), joined forces to create a GIS. This GIS can link with other partners in areas such as health insurance, benefits, family allowances etc., to issue calls for proposals that will assist with project definition and analyzing and conducting various stages of data collection.

The Overall theme of Child Development includes:

- Interactions and contexts: familial, social, economic, environmental
  Intellectual, educational, vocational
- Perinatal Health (behavior, accidents, diseases, etc.) and environmental exposures

Eighty or more projects are subsumed in the context of a thematic group. Project coordinators draft goals and issue project proposals. The project team, in conjunction with GPS, and under the supervision of the Scientific Council, work to address steps and procedures for observations, questionnaire content, and ensure overall consistency and taking care not to over burden families.

Membership in the EDP (permanent population sample) of INSEE (linkage with census data and vital statistics, and perhaps other sources) includes:
- At 6-11 years (perhaps every 3-4 years): School health
- Entering kindergarten until exiting the school system: Data collection, monitoring of Education (Depp)
- Continuously: Medical consumption data (prescriptions, drugs, biological, etc.), family benefits (CAF).

**Records on file at maternity**

- Questionnaires (parents and children) completed face-to-face or by telephone
- Tests (psychological, psychomotor, etc.) simplified for non-professionals
- Days after monitoring including nutrition.
- School system data (curriculum, assessments...)
- Medical Examinations (mainly in schools)
- Medical data from external sources (books, social security, etc.)
- Data on family benefits and other financial support paid to families (CAF)
- Variables locations (schools, kindergartens, industrial activities, etc.) through GIS (Geographic Information Systems)
- Data from environmental exposures systems surveillance and geo-coded

**Biological samples taken at birth.**

Initial Sample: Births during the 4x4 day of the new EDP (2009)

- First National Survey
- Home interviews (INSEE): Occur at 6-8 weeks, 3 years old, 6 years old, etc.
- Telephone interviews: Occur at 1 year old, 2 years old, and between 3 and 5 years and later, etc.
- Review of School Health: Occurs at 6 and 11 years old
Description of Databases

Brian Lenihan, on behalf of the Minister for Health and Children, has released Ireland’s first publication addressing the state of childhood development in Ireland. The publication was released in 2007 and is entitled *The State of the Nation’s Children, Ireland 2006*. (Website: [www.omc.gov.ie/viewdoc.asp?Docid=408&CatID=13&mn=&StartDate=1+January+2007](http://www.omc.gov.ie/viewdoc.asp?Docid=408&CatID=13&mn=&StartDate=1+January+2007))

This report covers many aspects of children’s lives aged 0-18 including their health, behavioral and educational outcomes, relationships with their parents and friends, and services available to/accessed by them. The report utilizes administrative, survey and census data. The ministry has a commitment to improving data about children as stated in a recent Social Partnership Agreement, entitled *Towards 2016: Ten-year Framework Social Partnership Agreement 2006-2015*. The Ministry’s Office ([www.omc.gov.ie](http://www.omc.gov.ie)) had assistance to compose the report from the:

- Central Statistics Office ([www.cso.ie](http://www.cso.ie))
- Health Promotion Unit at the National University of Ireland, Galway
- [www.nuigalway.ie/health_promotion/](http://www.nuigalway.ie/health_promotion/)

The State of the Nation’s Children report presents data for children by age categorizing them into groups of children ages 0-4, and 5-9. In the databases themselves, these groups are likely broken out by year.

**INDICATORS INCLUDED IN DATABASES**

Demographics and Vital Statistics

- Number of children in the population
- Number of non-Irish national children in population
- Number of Traveller children (minority Irish population that is culturally distinct and which enjoys special legislative support)
- Child mortality and child mortality by cause
- Children by age group and gender living with a lone parent
- Educational attainment of head of household for children by age group
- Data for above from 2002 Census information
Education and Child Care

- Attendance at school
- Preschool children's childcare arrangements by type
  - The Quarterly National Household Survey. Data is mostly for school-aged children

Health

- Number of infants breastfed (exclusive or combined) on discharge from hospital by mothers’ age group (1999-2003).
- Mother’s occupation (2003) and by geographic area.
- Number and rate (per 10,000) of children registered as having an intellectual disability, by age group, gender, and severity (2005)
- Number of children registered as having a specific physical or sensory disability, by age group and gender (2005).
- Immunization uptake rates by type and by health board at 12 months (2000-2004); Immunization uptake rates by type and by health board at 24 months (2000-2004)
  - Irish statistics on immunization are compiled by the Health Protection Surveillance Centre (HPSC) using data from the former health board areas. There is no national database on immunization. National Health Services Performance Indicators, Department of Health and Children, Patient Treatment Register, National Treatment Purchase Fund; The National Psychiatric In-Patient Reporting System (NPIRS) database maintained by the Health Research Board.
- Percentage of mothers of newborn infants visited by a Public Health Nurse within 48 hours of discharge from hospital, by former health board area (2003-2004)
- Percentage uptake of Child Health Core Screening Program at 7 to 9

- Developmental screening at 7-9 months by area medical officers does not appear to be available in some geographical areas. The highest percentage coverage (68%) is in the former Western Health Board area.

- Number of infants by age in months groups (3-6; 6-12; 12+) on hospital waiting lists, by hospital and waiting time and by type of procedure (2006)

- Number of admissions aged under 18 to psychiatric hospitals, by age group, gender, diagnosis, SES, and discharge (2001-2005).

- Antenatal care

**Child Welfare**

- Cases reported to Child protection services.
  - Most of these data are not presented as aggregated by age. They are from the Childcare Interim Dataset and are likely to include age.

- Social, Emotional and Behavioral Outcomes (age 10 and older with the exception of self-esteem data on children aged 8 and older).
  - Teenage pregnancies as births to girls aged 10-17 as a percentage of all births.

- Children in care (gender, type of care, and length of stay as reported by former health boards).
  - The data for Education and Child Care, Health and Child Welfare is taken from: a range of sources has been used, including data from, the National Perinatal Reporting System, a Quarterly National Household Survey, Hospital In-Patient Enquiry. These HIPE records data are on in-patient and day case discharges from all publicly funded acute hospitals and are managed by the Economic and Social Research Institute. The National Intellectual Disability Database (100% of those accessing services) and the National Physical and Sensory Disability Database (68% of those accessing services) held by the Health Research Board. Childcare Interim Dataset, held by the Dept. of Health and Children.

- Children’s relationships with their parents and peers.
  - This data is largely from the 1998/2002 Health Behaviour in School-aged Children (HBSC) surveys and the 2000/2003 Program for International Student Assessment (PISA) surveys and is for school age children 10 and older. It includes data on the child’s relationship (communication) with parents, number of friends, and bullying.

- Environmental supports and levels of economic security, including relative and
consistent poverty

Special Projects, Reports and Initiatives


Within the recent partnership agreement “Towards 2016”, there is an explicit commitment to the development of a data strategy on certain areas of children’s lives, and the purpose of this informational document is to set out the steps that will be taken in developing this Strategy. The aim of this process is provide an evidence base for the development of an overarching data strategy on children’s lives. The Strategy itself will set out visions, goals, principles and actions to support the collection, compilation and dissemination of data and will facilitate the utilization of good quality, easily accessible, internationally comparable information about children in Ireland.
The Netherlands

Demographics and Vital Statistics:
www.cbs.nl
www.cbs.an

Description of Databases

Statistics Netherlands is responsible for collecting, processing and publishing statistics to be used in practice, by policymakers and for scientific research. In addition to its responsibility for (official) national statistics, Statistics Netherlands also has the task of producing European (community) statistics. The legal basis for Statistics Netherlands and its work is the Act of 20 November 2003 governing the central bureau of statistics (Statistics Netherlands).

On 3 January 2004, Statistics Netherlands became an autonomous agency with legal personality. There is no longer a hierarchical relationship between the Minister of Economic Affairs and the organisation. However, the minister is responsible for setting up and maintaining a system for the provision of government statistical information; in other words the minister is politically responsible for legislation and budget, for the creation of conditions for an independent and public production of high quality and reliable statistics. The costs of tasks and activities undertaken to put this legislation into practice are accountable to the government’s budget.

The information Statistics Netherlands publishes a multitude of societal aspects, from macro-economic indicators such as economic growth and consumer prices, to the incomes of individual people and households. Statistics Netherlands’ statistical programmes (the long-term statistical programme and the annual work programme) are set by the Central Commission for Statistics. This is an independent commission that watches over the independence, impartiality, relevance, quality and continuity of the statistical programme. The Director-General decides autonomously which methods to use to make these statistics, and whether or not to publish results.

Statistics Netherlands aims to reduce the administrative burden for companies and the public as much as possible. To this end it uses existing administrative registrations of both government and government-funded organisations. The information from these files is supplied to Statistics Netherlands free of charge. Only if they do not contain sufficient information, Statistics Netherlands is allowed to conduct supplementary surveys among companies and private persons. Companies are usually obliged by law to supply information to Statistics Netherlands and can be forced to cooperate under certain circumstances; Statistics Netherlands may use sanctions such as administrative fines. For its part
Statistics Netherlands is obliged to keep all individual data confidential. As an exception data sharing with Eurostat, NSIs in EU member states, Dutch Central Bank and academic researches is allowed under certain restructures.

**INDICATORS INCLUDED IN DATABASES**

**Demographics and Vital Statistics**

Most data are not given by age and there is no breakdown for preschool or kindergarten available at this site.

- Live Births by sex and year
- Population by age (0-4, 5-9) gender and distribution across the Dutch Antilles
- Life expectancy of the Population of the Netherlands Antilles by Age (0 and 5 years of age) and Sex
Description of Database

Statistics Norway produces statistics on important aspects of the Norwegian society. Statistics Norway's activities are governed by the Statistics Act.

Statistics and analyses are available free of charge on the website. There are also copies of their paper publications. The statistics may be used free of charge by everybody as long as Statistics Norway is quoted as the source.

Current statistics are announced four months in advance. Nobody has access to the statistics before the time of release. Information about how the statistics are produced is available including information about collection methods, explanation of terms and information about sources of errors. Most of Statistics Norway's statistics and analyses are published in Norwegian and English.

Statistics Norway carries out commissions that may involve preparing statistics and analyses within special areas, or special organization of statistics and analyses. The party that orders such a commission must cover the costs. Price is always quoted before the order is confirmed.

Micro data may be communicated to research and for planning purposes. Non-sensitive micro data may on certain specified conditions be distributed with a notification to the Data Inspectorate. Delivery of sensitive data assumes as a main rule that the researchers in addition have concession from the Data Inspectorate, and that the data have been made unidentifiable.

Protection of individuals and establishments/enterprises is vital. Statistics Norway never publishes information that can identify individuals. The Law on protection of personal data and guidelines from the Data Inspectorate specify rules and procedures for the treatment of personal information with particularly strict routines for sensitive personal information.

Statistics Norway is committed to reduce the response burden when collecting survey data, both by changing from forms to the use of administrative registers, offering the possibility to report electronically, improving the questionnaires and by coordination of the samples of persons/enterprises that are questioned.
INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Live births and late fetal deaths.
- Confinements of single and multiple births, by sex.
- Age-specific fertility rates and total fertility rate.
- Average age at birth.
- Total fertility rate, by county.
- Live births, by parity.
- Live births, by parity, cohabitation status of mother and county.
- Number of children distributed, by age and cohort.
- Age-specific death rates for males and females.
- Life expectancy (remaining years for males and females at selected ages)
- Perinatal and infant mortality.
- Life tables.
- Expectation of life for males and females at selected ages, by county.
- Adoptions, by type of adoption, sex and age (Under 3, 3-4 & 5-6).
- Inter-country adopted, by sex, age and previous citizenship.
- Stepchildren adoptions. Adoptive parent’s relationship to the child.
- Stepchildren adopted, by sex and age.

Education and Child Care

- Children in kindergarten, by age, hours of attendance per week, and ownership
- Kindergarten, by ownership structure
- Fees and user payments for kindergarten
- Households’ payments in kindergarten (Rates of change)
- Children in family day-care centres, by age and weekly attendance

Health

(Represented in the National statistics by Health Surveys)

Child Welfare

- Children under protection, by age (< 2, 3-5 years) and type of assistance.
- New cases of children placed under protection, by age and reason for intervention.
- New cases of children placed under protection, by age and type of assistance.
New cases of children placed under protection, by age and who reported the case.

Residents in children's institutions, by type of institution, sex and age (0-2, 3-6 years).

Special Projects, Reports and Initiatives

The Norwegian Mother and Child Cohort Study

www.fhi.no/eway/default.aspx?
pid=238&trg=MainArea_5811&MainArea_5811=5903:0:15,3046:1:0:0:::0:0

The Norwegian Mother and Child Cohort Study (MoBa) is an ongoing pregnancy cohort study, with the aim of comprising 100,000 pregnancies by 2008. The study is based on questionnaires to the mother and father, and the collection of biological specimens from the mother, father and child. The main purpose of the study is to find causes of diseases. In the following pages you will find information especially intended for researchers who want to use the data for research but also for the participants in the MoBa study. The pages also contain a list of references and research results for general interest.

The purpose of this study is to find causes of serious diseases among mothers and children. Approximately 100 subprojects with specific research questions have been suggested. These questions are mainly related to environmental factors, such as medications, nutrition, infections and work exposure. Genetic factors as well as the interplay between genes and the environment will be studied. Blood samples from as many fathers as possible will also be collected, enabling association studies between genes and diseases.

Background
A number of diseases among mothers and children cannot be prevented or treated efficiently, primarily due to the inability to understand causal mechanisms. We know, for instance, little about the causes of prematurity, congenital malformations and stillbirths. Cancer, rheumatoid arthritis, severe allergies, diabetes, autism and cerebral palsy are examples of conditions that occur in childhood and that should be prevented or at least treated efficiently. For mothers, an understanding of the etiology of diseases such as pelvic pain, postnatal depression, gestational diabetes, breast cancer and other chronic diseases is largely incomplete.

Design
This is a cohort study. A large group of pregnant women are recruited to take part in a follow-up that may last for many years after childbirth. Information about outcomes, for example different diseases in mothers and children will be studied in
an attempt to find information about potential causal factors. The cohort design allows nested case-control studies to be conducted whenever additional exposure data are collected or blood samples analyzed.

Sample

Norway has ~4.5 million inhabitants, and ~55 000 births a year. The target population comprises of all pregnant women and the fathers in Norway during a 4-5 year period. The sample size is 100,000 women. If this number was not reached by the year 2005, data collection would continue until the sample size is reached. The sample is still being collected and is estimated to reach 100,000 pregnancies in 2008.

There are no exclusion criteria. All hospitals and maternity units with more than 100 births annually, altogether 52 units, are included. For practical reasons, the sampling frame comprises pregnant women who attend routine ultrasound examination. Together with appointments for ultrasound scanning in week 17-18 of pregnancy, the pregnant women receive a postal invitation that includes an informed consent form, the first questionnaire, an information brochure as well as consent form and questionnaire for the father. The pregnancy is the unit of observation, and a woman can participate in the study with more than one pregnancy. Each pregnancy is given an identification number, and all other data, be it from the mother, father, or the child, are linked to this number.

Data collection

About two weeks before the routine pregnancy ultrasound examination (around week 17), women are invited to participate in the study. They will receive an envelope containing an information folder, two questionnaires and a consent form. The questionnaires are focused on different exposures as well as health history. The women are informed of the voluntary nature of the project and the possibility to withdraw from the study at any time. Blood and urine samples from the women are taken at the same time as the ultrasound examination. More than 90% of fathers accompany their partner to this examination, and fathers will be asked to take part in the study with a separate consent. If the father agrees, a blood sample will be collected, and he will complete a short questionnaire on his own health, medication and occupational exposure. Soon after birth a blood sample from the umbilical cord and a second sample from the mother will be collected.

All filled-in questionnaires are sent by mail to The Medical Birth Registry in Bergen where they are registered, scanned, and verified. Furthermore, a series of identity checks is made, and the answers to specific questions are checked for logical content and consistency.

Questionnaires: (Questionnaire variables: www.fhi.no/morogbarn)

- The first questionnaire (Q1: 16 pages), received in pregnancy weeks 13-17, asks for data on outcomes of previous pregnancies, medical history before and during pregnancy, medication, occupation, exposures in workplace and at home, lifestyle habits, and mental health.
A food frequency questionnaire (14 pages) is sent to participants at about week 22 of pregnancy.

A third questionnaire is sent at 30 weeks (16 pages) and covers the woman’s health status during pregnancy as well as changes in work situation and habits.

A questionnaire when the child is 6 months (16 pages) has a focus on child health and nutrition as well as maternal disorders, well-being, and mental health.

Questionnaires at 18 months and 3 years have a main focus on the child’s developmental status.

A questionnaire is planned when the children are 7 years old.

The paternal questionnaire (16 pages) covers exposures at work, lifestyle, and medical history.

Health registries will be linked to the cohorts to find end-points. The Norwegian Institute of Public Health is responsible for five national registries of which the Medical Birth Registry (in Norwegian) and the Cause of Death Registry are the most important for Biobanks for Health. The Medical Birth Registry is of special relevance for the MoBa study. The Cancer Registry of Norway will provide opportunities for a series of research projects addressing the causes and mechanisms of many cancer forms.

After quality control, all data are entered into an Oracle database organized in many sub-components. The MBRN-record is added as well as all new variables generated by linkage or analyses of biological specimens. All biological samples are sent to a central biobank for registration, processing, and storage. Further follow-up after 7 years has not yet been determined.

Variables
Exposure variables include genes, psychosocial factors, infections, use of medication, nutrition, life styles, occupational exposure, use of health services, substance abuse and socioeconomic factors as well as chemical and physical factors in the environment. Health variables include maternal and paternal history and health outcomes for the mother and child detected during and after pregnancy.

The planned ten-year data collection period has a budget of 130 million NOK. The project is not yet fully financed, which means that the data collection period may be extended. Presently, collaboration with international research groups and funding agencies is of high priority.

Per Magnus, principal investigator
The Autism Birth Cohort

www.abc.columbia.edu

The Norwegian Institute of Public Health and Columbia University (USA), have jointly received a 13 million US dollar grant from the National Institute of Neurological Disorders and Stroke (USA) to fund one of the largest longitudinal studies of autism worldwide. The study is based on the Norwegian Mother and Child Cohort Study (MoBa), in which 100,000 pregnant women are recruited at the first ultrasound examination, and the women and their children are subsequently followed throughout pregnancy and as the child grows older. The autism sub-study is called the Autism Birth Cohort (ABC) Study.

Material and methods
In MoBa 100,000 pregnant women, about 100,000 children and about 70,000 fathers will be recruited into a large population based cohort, which we will follow at least until the children are 18 years of age. Follow-up of the cohort includes linkage to national health registries and questionnaires when the child is 6, 18 and 36 months. A questionnaire for 7-year-old children is currently being developed.

Blood samples are collected early in pregnancy (week 17) from all mothers and fathers, and a urine sample from the mother is also collected. Cord blood is collected from all newborn children at birth. New blood samples from mothers are collected after delivery.

Children with possible autism spectrum disorder diagnoses are identified based on data from questionnaires completed when the children are 36 months old. Possible cases of autism spectrum disorders and a control group are invited to participate in a clinical assessment. The clinical assessment comprises parent interviews, child psychiatric assessments and tests of developmental skills. The assessments are performed at a clinic designated for the purpose at the Nic Waal's Institute, which is a child psychiatry clinic in Oslo. The clinic is staffed by child psychiatrists, child psychologists and research assistants.
Description of Database

There is a growing realisation that ensuring the health of children should be at the heart of efforts to improve the health of the population as a whole and to help combat inequality. The Scottish Executive, in the White Paper Our National Health: a plan for action a plan for change (2000) identified the health of children as a clinical priority and stressed the need for NHS Scotland to work in partnership with local authorities and other agencies to provide integrated services for children.

INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

➢ Child Mortality

Health

➢ Immunizations
➢ Obesity
➢ Breastfeeding
➢ Hospital admissions
➢ Obesity
➢ Extra support needs of children (mental health, physical health)
➢ Unintentional injuries

Special Projects, Reports and Initiatives

Growing Up in Scotland

www.growingupinscotland.org.uk

The idea for the Growing Up in Scotland project (GUS) grew out of a longitudinal scoping study commissioned by the Scottish Executive Education Department (SEED) in 2000 which highlighted a lack of existing data relating to two important developmental phases in children’s lives - early years and the transition into
adolescence. The scoping study recommended that the Executive consider commissioning a longitudinal study in one of these areas. This recommendation was realised in 2003 when the Growing Up in Scotland study was commissioned by the Scottish Executive Education Department (SEED). Growing Up in Scotland is a large-scale longitudinal social survey designed to examine the characteristics, circumstances and behaviours of children from birth to late adolescence (and possibly beyond). It will form a central part of the Executive’s strategy for the long-term monitoring and evaluation of its policies for children, with a specific focus on the early years. A contract to undertake the development of the study and the first two years fieldwork and analysis was awarded to the Scottish Centre for Social Research in collaboration with the Centre for Families and Relationships at Edinburgh University. Although the survey has various features in common with other cohort projects, such as the Millennium Cohort Study, it also differs in a number of important respects. For example,

- it has a specifically and uniquely Scottish focus
- it is driven specifically by the needs of policy
- it has a particular focus on service use, awareness and contact in various key stages of childhood - e.g. health, education, childcare
- it has an intensive focus on the early years of children’s lives.

As part of the development of the study, a scoping exercise was undertaken, first, to ensure that the design and content of the study matched as closely as possible the identified needs of its core policy users and, secondly, to help to embed the main study in the broader academic and policy community. This involved interviews with policy makers, a series of consultative seminars with representatives of the academic community, discussions with other researchers and a desk-based review of previous studies and existing instruments.
Spain

Demographics and Vital Statistics:

Education and Child Care:
www.ine.es/inbmenu/mnu_educa.htm

Health:

Child Welfare:
www.ine.es/jaxi/menu.do?type=pcaxis&path=%2Ft25%2F&a072%2F&file=inebase&L=0

Description of Databases

The statistical publications of the Ministry of Health and Consumer Affairs do not contain all the statistical data that can be offered. Agencies, institutions and researchers can seek additional information from their databases as material for the development of their studies. The transfer of data by the Ministry of Health and Consumer Affairs is free. All requests will be required to sign a statistical confidentiality that protects and covers the statistical unit informant. Data that could lead to identify directly or indirectly any natural or legal person is not provided.

The following data repositories are included:

- Catalog National Hospitals
- National Death Index
- National Health Survey of Spain
- Statistics Health Establishments with Regime Internship
- Registry of Hospital releases

One can download some of the Health statistics but they are in a format not recognized by Microsoft or Adobe programs. Spain does collect data on children 0-15 years but not all appear to be broken down by age groupings.
www.ine.es/inebmenu/mnu_salud.htm
INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Population by sex, age, place of birth, place of residence and nationality
- Births (classified by the age of the parents, gestation period, weight of the newborn, order of birth, profession of the mother, profession of the father, nationality of the parents; Births are also classified by the age of the parents, multiplicity, maturity, normality, residence of the mother, vitality, health care)
- Deaths by age (0, 1, 2, 3, 4, 5 years) and year of birth, sex, late fetal deaths, deaths by sex and place of registration (provisional results), place of residence (definitive results) and place of death.
- Late fetal deaths are also classified by the age of the parents, gestation period, weight of the newborn, order of birth, profession of the mother, profession of the father, and nationality of the parents.

Education and Child Care

- Preschool. Units school year (2000-05) by regions / provinces, age (0-2; 3-5) type of center (public/private).
- Infant Education / Preschool (Students enrolled (during 2000-01) by regions / provinces, by type of center and sex)

Health

- Mortality by cause of death in Spain and autonomous regions by age groups of under 1 year of age, 1-4 and 5-15 years of age.
  - www.ine.es/jaxi/tabla.do?path=/t15/p414/a2005/l0&file=01008.px&type=pcaxis
- Deaths from causes (detailed list), by age, sex, place of residence.
- Deaths of children under one year from causes (roster child), sex and age.
- Deaths of children under one week from causes (perinatal list), sex and age.
- Fetal deaths by cause (perinatal list), sex and weeks of gestation.
- Transmissible spongiform encephalopathies human
➢ AIDS: Cases by age (< 1, 1-2, 3-4, 5-9 years of age), year of diagnosis and data type.
  • www.ine.es/jaxi/tabla.do?path=/t15/a043/a1998/l0&file=s1003.px&type=pcaxis&L=0

➢ Information system microbiological

➢ Quality of bathing water

➢ Pesticide Registration (biocides)

➢ Quality of drinking water and public consumption

➢ Home and Leisure Accident

➢ Spanish Observatory on Drugs

➢ Voluntary terminations of Pregnancy
  • www.ine.es/jaxi/menu.do?type=pcaxis&path=%2Ft15%2Fa044&file=inebase&L=00

Child Welfare

➢ Incidence and protective measures that have taken place in the field of adoption, and guardianship of minors under the age of 18 years (not broken down by age)
Sweden

Demographics and Vital Statistics:
www.ssd.scb.se/databaser/makro/maintable.asp?
omradekod=BE&omradetext=
P
Population&lang=2&langdb=2&xu=C9233001&yp=tansss

Health: www.socialstyrelsen.se/english

Description of Databases

The Centre for Epidemiology, The National Board of Health and Welfare
www.socialstyrelsen.se/english

The National Board of Health and Welfare publishes statistics in the areas of Health and medical care (including causes of death) and Social services. The statistics are published in reports and statistical databases. In the English web-pages you will find items which are partly or completely in English. More statistics are available in Swedish.

Swedish Medical Birth Registry
Includes more than 100 variables from pregnancy to birth and encompasses the total population. Each individual has a personal ID that can be linked to other national registries, including; the national education registry; the in-patient registry; and the income registry. There is no preschool registry either for placements or attendance, and the national education registry has no standardized test data until the age of 11. The aim of the data is to support public information, as well as the analysis of risks during pregnancy and at delivery. Data exists on all deliveries in Sweden from 1973 including the previous gestation as well as the new-born child (About 85,000 – 120,000 deliveries a year).

The registry is a valuable source of information for reproduction epidemiology. In order to make full use of it, an understanding of its deficiencies is necessary. Some data are missing. For example, records for a small percentage of all infants (0.5-3.9 per cent) are missing completely, and data from ante-natal care clinics or pediatric wards are incomplete. The most serious data loss is probably that related to infant diagnoses. Wherever possible, it is useful to supplement information on infant diagnoses with data from the hospital discharge registers of neonatal wards and from the Registry of Congenital Malformations. Single items of information may also be missing to a varying degree. Missing data significantly affects estimates of prevalence but has only a slight effect on risk estimates. A report summarizes the contents of the Swedish Birth Registry and analyzes its quality.

For reproduction epidemiology, studies of the following variables are of particular importance: gestation duration, birth weight, and the incidence of congenital
malformations, multiple births and infant survival. (For congenital malformations, the Register of Congenital Malformations is also used.) These variables are fairly reliable. In most cases, adequate data can be obtained with the hierarchical system used for estimates of gestational duration. But for studies of extreme outcomes, such as those involving very low birth weight, caution must be exercised due to the potential for misrepresentation. There are indications that omissions with regard to stillbirths are selective; but only 1-2 per cent of records are missing for most years, which is an acceptable level. Also note that the rate of stillbirths is slightly underestimated in the Medical Birth Register. For other characteristics, detailed knowledge of data quality and error risks is necessary.

With regard to exposure data, information on smoking during early pregnancy is relatively good (4.2-9.0 per cent missing), while information on maternal drug use is incomplete. Some estimates indicate that the reporting/recording rate for drugs, such as those used for epilepsy and hypertension, is perhaps 60-70 per cent. All exposure data are obtained prospectively (i.e. before the outcome of the pregnancy is known), which will have little effect on risk estimates. Lack of data on the exact timing of various exposures can bias risk estimates. Missing data will obviously affect all estimates of prevalence, but will usually have little impact on risk estimates if the lack of information is random.

In order to maintain the registry at a reasonably high standard, it is recommended that evaluations be made at regular intervals, and that the effects of the increasing use of computerized medical records be closely monitored.

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**Swedish National Institute of Public Health (SNIPH)**

[www.fhi.se](http://www.fhi.se)

The Institute’s purpose is to promote health and prevent ill-health and injury, especially for population groups most vulnerable to the greatest health risks, by providing the Government, central agencies, municipalities and county councils with knowledge. The Institute has three principal functions:

1. To monitor and coordinate the implementation of national public health policy with other central agencies. This function is comprehensive in nature and requires the Institute to devise indicators relevant to both the public health objectives and to the policy being pursued.

2. To be a national centre of knowledge on public health to the Government and its agencies, as well as to regional authorities and municipalities. The Institute’s role as a centre of excellence also includes monitoring the development of theory and knowledge in all spheres of public health.
3. To exercise supervision in the fields of alcohol, tobacco and illicit drugs. The Institute must issue regulations and general recommendations relating to alcohol, collect national data on illicit drugs and assume responsibility for product control and printed warnings on tobacco products according to EU regulations.

No information on their monitoring activities is available in English

**Living Conditions of Children and their Families**

Sweden produces, yearly since 1998, comprehensive statistics about children's living conditions. The statistics provide information about children's families, children with foreign background, about parents' employment, separation between parents, economical conditions, and brief statistics about child care. In 2001 an overview of children’s health was presented, and in each year many tables are presented, usually using one particular background variable (e.g., mothers age at the birth of the child, foreign and Swedish background, parents’ level of education, municipality group and type of housing).

Special publications that provide in-depth information within different fields are published on an irregular basis. The latest report Children, segregated housing and school was published in February 2007. In 2004 Time children spend with their parents was published. Children's share of the cake - prosperity and poverty among children describes the economical situation of children and their families. Children's living conditions was published in the fall of 2005. The report is based on the Living Conditions Survey in 2002 and 2003 where 10-18-year olds are interviewed and where, in the regular survey, family conditions for today's children (aged 0-18) were emphasized.

In cooperation with the Children’s Ombudsman, Up to the age of 18 is published every third year, the last time being November 2007. It is a publication with brief descriptions about children’s families, child care, school, health and lifestyles, diseases and injuries and children in trouble.

Up to the age of 18 can be found on the Children's Ombudsman webpage. [www.bo.se/Adfinity.aspx?pageid=85](http://www.bo.se/Adfinity.aspx?pageid=85)

**Education of the population**

For more information, e-mail fornarn.efternamn@scb.se

Information on the website does not appear to be for young children.

**School system and child daycare**

Preschool activities and school-age childcare: For more information, e-mail barnoms@scb.se

Expenditure on preschool activities, school-age childcare, schools and adult education. For more information, e-mail utbkostnader@scb.se

The Swedish National Agency for Education is responsible for the presentation of
data at all levels of the education system, except for university level statistics. The national follow-up system provides quantitative, recurrent data on the development in the education system.

In general, the quality of statistics in Sweden can be qualified as good. The statistics presented do not, however, represent any precisely fixed values, but only estimations of them. The concept estimation refers to the fact that the statistics (the set of statistical data) involve an element of uncertainty. Sources of uncertainty are mainly shortcomings in the basic registers, missing data and measurement and processing errors. In order to minimize errors, extensive examination, correction and supplementation work is being performed.

Report: Descriptive data on preschool activities, school-age childcare, schools and adult education in Sweden 2006 (www.skolverket.se/sb/d/190)

This report provides a general description of current childcare and educational organization in Sweden, showing child/pupil and staff strengths along with expenditure and results for the various types of childcare and schooling.

Summary: This report gives an up-to-date, comprehensive picture of how preschool and adult education is organized in Sweden (eg. the number of children/pupils and of staff in different forms of schooling). It also gives an account of the expenditure of the different forms of schooling and the results that are being achieved. It is based on the statistics that are supplied to the national monitoring system for the education sector.

**INDICATORS INCLUDED IN DATABASES**

**Demographics and Vital Statistics**

- Mean age at birth of the first child by region and sex (Year 1970-2006)
- Total fertility rate by region and sex (Year 1970-2006)
- Population by region, marital status, age (individual years 0-5) and sex. Year 1968-2006
- Deaths by region, age (the year of birth) and sex. Year 1968-2006
- Deaths by region, age (during the year) and sex (Year 1968-2006)
- Migration by region, age (individual years 0-5) and sex (Year 1997-2006)
  - Note: some of these statistics are also available for part of 2007).

**Education and Child Care**
See above

Health

- Identification of patient: maternal PIN, infant PIN, maternal place of residence (parish) at delivery, delivery hospital, antenatal-care centre (1998-)

- Social factors: cohabitation, work outside home (1982-), occupation (1982-), parents’ nationality, mother's country/country of birth, year of immigration (-1998), year of emigration (-1998);


- Method for assisted conception (1994-) use of contraceptive pills or IUD before pregnancy (1982-) previous CS, inc. year (1999-)

- Pregnancy: LMP date: expected date of delivery according to LMP and sonography (1982-); CVS or amniocentesis, inc. date and outcome (1994-) selected diseases at first visit to antenatal clinic; drugs used during pregnancy (1995-); number of antenatal visits (1998-); date of first antenatal visit (1998-); date of admission to delivery unit pregnancy duration (weeks, days);presentation of infant; delivery diagnoses; operations at delivery: CS, forceps, vacuum extraction, other analgesia, anaesthesia with specification; induction of delivery (1998-); placental weight (-1982); number of umbilical arteries (-1982) ruptures (1999-); perineotomia (1999-)

- Infant :date and time of birth; stillborn/live-born; date of death, underlying cause of death; sex; birth weight; birth length; head circumference; multiple birth, inc. number

- Apgar score at 1, 5, 10 minutes; infant diagnoses; operations and other treatments of infant

Above data is from the National Birth Registry
Child Welfare

See above under “Descriptions of Databases”
Description of Database

The Office for National Statistics (ONS) is the government department responsible for collecting and publishing official statistics about the UK’s society and economy. ONS is the principal provider of official statistics about the UK. Its information is used by government to make decisions about society and the economy, and by people to better understand their country. ONS carries out the ten-yearly census and is also responsible for the registration of vital events in England and Wales through the General Register Office (GRO).

INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Births and Deaths Extracts: Annual extract of births and deaths, individual records (for health authorities only).
  - Used for a variety of applications e.g. Monitoring local trends, preparing annual reports, outcome linkage, quality checking local statistics. Individual records extracted from the births and deaths registrations datasets.

- Childhood morbidity and mortality- Age groupings are not clearly available.

Education and Child Care

- Awareness of provision
- Childcare facilities
- Day nursery numbers
- Demand for childcare and nursery education
- Nursery education
- Participation rates (under-five years of age)
- Playgroup numbers
- Preschool provision
- Staff/teachers (preschool)

Health

- Asthma by age (0-4; 5-9 years of age)
- Immunization programs
- Infant deaths/mortality
- Infant feeding practice
- Sudden infant deaths

Child Welfare

- Adoptions
- Care orders
- Child protection
- Day care for children
- Disabilities of children looked after
- Foster placements
- Playgroup sessions
- Respite care for children
- Staff in children's homes
- Child data is aggregated by age group (1-4 and 5-9 years of age).

Special Projects, Reports and Initiatives

Office Growing Up in Scotland

www.ons.gov.uk/about/who-we-are/our-services/longitudinal-study

ONS is a very large data set that links half a million people's census records from 1971 to 2001 and beyond. The ONS Longitudinal Study is an approximate 1% sample of the population of England and Wales. Links have been made between censuses as well as information on events such as births, deaths and cancer registrations.

The ONS Longitudinal Study contains individual-level census records. These individual records are linked between successive censuses and data for various events. This combination of records if for a 1% sample of the population of
England and Wales.

The Centre for Longitudinal Study Information and User Support (CeLSIUS) provides support for academic users of the LS and maintains a searchable list of all publications that use LS data.

Studies using registration event data as outcomes:
The LS was originally devised because of the lack of information collected at registrations of birth, cancer and death. The individual-level data of the LS mean that person-years at risk can be calculated for epidemiological studies.

The studies that make best use of LS data are those that link social, occupational and demographic information to vital studies on topics such as mortality, cancer incidence and survival, and fertility patterns. The ability to combine detailed personal characteristics with area characteristics has proved useful in many studies of health, especially those looking at environmental effects on health, and those on inequalities in health.

Studies using linked census data:
Linked census data for members of the LS allow researchers to examine change by investigating the same people at two or more censuses.

Studies of social mobility have examined the change of class position by age. Information on co-residents of LS sample members has been used to study inter-generational mobility. It is now possible to compare class mobility from 1971 to 1991 with mobility from 1981 to 2001.

The size of the LS makes it suitable for the study of ageing. Studies have used the information collected on the co-residents and family status of the LS sample to examine changes to household and family arrangements that come with age.

Census forms began to obtain information about addresses one year ago. The linked census data in the LS have been used to study ten-year migration patterns between censuses. Also, information on place of enumeration in 1939 has been used to study migration over longer periods.

The addition of 2001 Census information to the LS has meant that individual-level ethnic identity changes and changes in long-term illness status between 1991 and 2001 can be studied for the first time.

One of the major strengths of the ONS Longitudinal Study is its size. It represents 1% of the population of England and Wales, with a sample of about 950,000, and covers over 30 years of census and event records. This combination of large sample size and long follow-up time makes it unique. For studies in certain areas, such as ethnicity, the LS is the only longitudinal study large enough to give statistically useful sample sizes. The data set also includes information on LS members and co-residents of LS members, and information on people in
communal establishments who are excluded from most national surveys. Census coverage rates and the linkage and trace rates obtained in the LS compare very favourably with response rates achieved in surveys.

The LS’ main limitation is the relatively restricted range of variables available. For example, there is no information on smoking or on income. It is not possible to go to the sample and gather information on extra variables, as is sometimes the case when dealing with surveys. However, it is possible to link information on the characteristics of areas that LS members live in (for example, deprivation score of the ward of residence). The LS is also restricted to England and Wales, though a Scottish LS exists and guidance is being developed for comparative research. A Northern Ireland Longitudinal Study has recently been launched.

For certain studies, another data set may be more suitable than the LS. Some suggestions are provided below:

British Cohort Studies:
- 1946 (MRC National Survey of Health and Development): cohort of 5,362 births in 1946 followed up to the present day. Contains data on subjects’ physical and mental health, including observational measures, diet and lifestyle, and family, employment and social circumstances.
- 1970: cohort of 17,198 births in the UK in the week 5-11 April, 1970 followed up to 1996. Contains medical data and data on physical, educational, social and economic development.
- Millennium Cohort Study: began with a cohort of 20,000 births in the UK for a twelve month period from June 2001. The second sweep is now taking place with the children at around 3 years of age. Fieldwork started in September 2003 in England and Wales, and December 2003 in Scotland and Northern Ireland.
- British Household Panel Survey: cohort of 5,500 households and 10,300 individuals in Great Britain followed up from 1991 to (so far) 2007.

This site ([www.iser.essex.ac.uk/ulsc/keeptrack/index.php](http://www.iser.essex.ac.uk/ulsc/keeptrack/index.php)) was developed from the joint efforts of the Office for National Statistics (ONS) of the United Kingdom and the UK Longitudinal Studies Centre (ULSC). The ULSC is funded by the Economic and Social Research Council (ESRC), and is a part of the Institute for Social and Economic Research (ISER) at the University of Essex.
AUSTRALIAN DATABASES
National Databases

Australian EDI:  www.australianedi.org.au

Description of Databases

Birth Registry
The responsibility for birth registration in Australia lies with individual state and territory Registrars of Births, Deaths and Marriages. A Birth Registration Statement is completed by at least one of the baby's parents. This information is the basis of the data provided to the Australian Bureau of Statistic (ABS) for processing and production of birth statistics. The Australian Bureau of Statistics (ABS) is the central statistical authority for the Australian Government and, under the Government-to-Government arrangements entered into with the states pursuant to the Statistics (Arrangements with States) Act 1956, provides statistical services for state and territory governments.

Birth data is supplied to the ABS, on a monthly basis and in an electronic format, from each of the Registrars. Processing of this data is carried out by the Health and Vitals Statistics Unit (HVSU), located in the Queensland Office of the ABS. The systems used to collect and process the data are constantly being reviewed and developed in order to make the most effective use of technology.

Births statistics are an essential component in the calculation of Australia's estimated resident population, used in determining the number of seats in the House of Representatives for each state and territory, as well as in the distribution of Australian Government funds to state, territory and local governments. They are also critical for measuring trends in fertility and for use in population projections.

Australian Early Development Instrument (AEDI)
www.australianedi.org.au

The AEDI is an Australian adaptation of the Canadian Early Development Instrument (EDI) developed through the Australian Early Development Index: Building Better Communities for Children project. It is a teacher completed checklist designed to measure a child's ability to take advantage of the available school learning environment and to report early child development outcomes in five areas: physical health, emotional maturity, language, communication skills and general knowledge.

The Early Development Instrument (EDI) is a population-based measure of early development outcomes in young children. It is primarily used for assessing participation readiness in school activities and information is reported at an
aggregated level rather than for individual children. There are five subscales which serve as indices of domains deemed important in effective participation in traditional school activities.

These include:

(i) Physical health and well-being
(ii) Social competence
(iii) Emotional maturity
(iv) Language and cognitive development (LCD)
(v) Communication Skills

Each index is represented by subsets of items varying between numbers 9 (the CS subscale) and 30 (the LCD subscale). Each item consists of a statement that is a verbal descriptor of a skill, disposition, or behaviour. These statements are evaluated on a rating scale which ranges in number of categories from two to five, such as “Yes” (1), “No” (0) or “Excellent” (4), “Good” (3), “Average” (2), “Poor” (1), “Very Poor” (0). For each statement, a “Don’t know” option is also given but is not treated as being part of the scale. The “Don’t know” response is taken to provide no information and treated throughout the analysis simply as missing.

An informed teacher is asked to rate each child on each of the items. Typically, this means that the teacher has had the children in class for at least 5 to 6 months. The EDI instrument was developed by Offord Centre for Child Health Studies and has been used extensively by communities in Canada. The Offord Centre at McMaster University is the Canadian national repository for the EDI data collected.

Adaptation of the EDI to the Australian EDI

Adaptation of the EDI for use in Australia followed several steps: 1) Establishing content validity and utility as a community-level measure of early child development and readiness for school learning in the Australian context (Hart, Brinkman and Blackmore, 2003). Apart from minor wording changes to reflect common Australian English, the overall content and structure of the initial revision remained essentially unchanged from the original Canadian version. 2) Rasch scaling analysis to examine the psychometric properties of each of the five EDI domains. This analysis established that while all five domains had excellent reliability and validity in terms of the Rasch model, four of the domains (PHW, SC, EM, CS) could be further improved if they were modified from their existing five ordered response categories to three such categories. The Rasch analysis also identified nine items that could be safely eliminated without any loss of scale precision. 3) Modifications to the instrument recommended by the Rasch analysis were then formalized through a memorandum of understanding between the Offord Centre for Child Studies, the Centre for Community Child Health, the North Metropolitan Population Health Program and the Telethon Institute for Child Health Research. 4) Further validation of the AEDI through assessment of its concurrent, construct and predictive validity was undertaken as part of the Longitudinal Study.

The report on predictive validity is forthcoming.


Implementation
There are currently about 36,500 children in Australia for which AEDI data is available. A census administration of the AEDI (i.e. all Australian children aged 5 years 6 months – 6 years 5 months) would entail enumeration of just over 250,000 children.

Currently the decision to implement the EDI is undertaken by communities rather than by school district or state. Australia uses the suburb of about 4,500 people as their community level. Census tract is considered too small since many areas in Australia have only one or two teachers per community. Communities fund teacher relief from a variety of sources. Analysis and mapping costs are assumed by the Federal Government through the Federal Family & Community Services and Indigenous Affairs.

EDI data is available by community for most states with the exception of the Northern Territories. Coverage within a state varies. For example, Victoria has 20% coverage whereas Western Australia has 60% coverage. Currently AEDI is collaboratively funded with federal and community funds.

Initiatives
A proposal has been submitted to the COAG Human Capital Working Group to undertake either a census administration of the AEDI or a total national sample across the eight states.

South Australia will be going forward with administration of the AEDI to all of its incoming kindergarten children regardless of the success of the COAG initiative. It is expected that Victoria will also undertake a similar initiative.

Linkages
Currently there are no linkages between early child development population databases in Australia. Western Australia, however, has plans to link health, education, and crime with the census. They have an application to link the EDI with grades 3 and 5 in the education data (numeracy and literacy data). This will be the first time linkage has occurred at the community level. Other states do not have linkage facilities. Different departments collect their own data but there is not a system to link these departments except in Western Australia.
The National Schools Statistics Collection (NSSC)
This is a census, conducted annually as a collaborative arrangement between State, Territory and Commonwealth education authorities and the ABS. Data is collected from the relevant authorities on a range of issues relating to schools, students and staff in primary and secondary schools throughout Australia, from both the government and non-government sectors. Schools, Australia publishes information on the number, age, sex, year/level, category of school, apparent retention rate and participation rates of students at both the State and national levels. As well, information on school staff is published at State and national level.

The purpose of the collection is to provide nationally comparable data on primary and secondary schools, students and staff. Results are used extensively by governments and private organizations in a range of industries which supply the vast education market.

The scope of the schools collection consists of students and staff of all establishments which have as their major activity the administration or provision of full-time day primary, secondary and/or special education (or primary or secondary education by distance education). This includes establishments from both the government and non-government sectors.

Coverage rules are not necessary for the NSSC as, being a census, data is collected on the one day.

Child Welfare
The collection includes all child protection notifications made to authorized departments and relevant statutory authorities during the year 2005. Those State and Territory community services departments that can separate out child concerns from child protection notifications should do so.

The distinction between what is classified as notification and a child concern differs across jurisdictions. However as a guide, using the Western Australian definition, a child concern report is a report about a child to a community services department where there is no indication that a child may have been, or is at risk of being, harmed through abuse or neglect. In Western Australia this classification is assigned to referrals regarding concern about a child’s welfare related to the quality of his or her home environment or the standard of care that he or she is receiving, and where the precise nature of the issue or problem is unclear and requires further assessment. The response to a child concern report is not to investigate child abuse or neglect or harm to a child. It is to assess the concern for the child, the family’s circumstances, the need for services, to support the family and to assist them to access services. In contrast, a response to a notification has the primary goal of determining whether or not child abuse or neglect or harm has occurred and of protecting the child. The number of reports relating to child concerns should be provided as a separate figure along with an explanation of what is classed as a child concern report.
INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Number of children ever born by age of females
- Number of children ever born by age of females by Indigenous Status
- Proportion of couples with dependent children
- Proportion of One-parent families with dependent children
- Relationship in household by age and sex.
- Indigenous status by age by sex
- Proficiency in spoken English/language by Age

Education and Child Care

- Physical health and well-being (AEDI)
- Social competence (AEDI)
- Emotional maturity (AEDI)
- Language and cognitive development (AEDI)
- Communication Skills (AEDI)
- Number of students, age, sex, year/level (NSSC)
- Category of school (NSSC)
- Apparent retention rate and participation rates of students at both the state and national levels (NSSC)

Child Welfare

- Age of child
- Authorised department to which child abuse and neglect is reported
- Child protection notification (contacts to authorized departments)
- Family of residence
  - Two parent -natural: all two parent families where both parents are either the biological or adoptive parents of the child.
  - Two parent-step or blended: blended and reconstituted families (one biological parent and one step parent).
  - Single parent-female: all families with a female single parent. The parent may be the biological, step or adoptive parent.
• Single parent-male: all families with a male single parent. The parent may be the biological, step or adoptive parent.

• Other relatives/kin: relatives other than those referred to above. Also includes Indigenous kinship arrangements.

• Foster care: situations in which a child is living with foster parent(s) who receive a foster allowance from a government or non-government organisation for the care of a child (excluding children in family group homes).

• Other: all those not mentioned above. It includes non-family situations, such as hostels and institutional accommodation.

• Not stated: category is used when the family in which a child lives is not recorded or is unknown.

➢ Indigenous person (status)

➢ Investigation and Investigation outcome
The following categories are used:
• Substantiated: A finalised investigation is classified as 'substantiated' where there is reasonable cause to believe that the child has been, is being or is likely to be abused or neglected or otherwise harmed. Substantiation does not necessarily require sufficient evidence for a successful prosecution and does not imply that treatment or case management was, or is to be, provided.

• Child at risk: This category is only used in Tasmania when there are reasonable grounds to suspect the possibility of previous or future abuse or neglect or harm and further involvement of the department is considered to be warranted.

• Not substantiated: A finalised investigation is classified in this category where an investigation has concluded that there is no reasonable cause to suspect prior, current or future abuse or neglect or harm to the child.

➢ Investigation not finalized

➢ Person believed responsible

➢ Primary allocated caseworker
Relationship to child of the person believed responsible
- (Natural parent; Step-parent; Parent’s de facto; Sibling; Other relative/kin
- Foster parent; Residential-based staff; Other person with duty of care responsibility; Other child; Friend/neighbor; Stranger; Other; Not stated)

Source of notification (person who made report)
- Parent/guardian; Sibling; Other relative; Friend/neighbor; Medical practitioner; Other health personnel; Hospital/health centre personnel; Social worker/welfare worker/psychologist/other trained welfare worker; School personnel; Child care personnel; Police/Departmental officer; Non-government organization; Anonymous; Other; Not stated

Substantiation (report deemed true)

Type of abuse or neglect
- Physical abuse; Sexual abuse; Emotional abuse; Neglect

Type of action (for child protection notifications)
- Investigated; Dealt with by other means; Not investigated/not dealt with

Special Projects, Reports and Initiatives

Children in care and protection orders 2004-2005

The aim of this collection is to obtain national data on children for whom the State has made some form of legal intervention for protective reasons. These data are required for both the Australian Institute of Health and Welfare’s data collection and for the performance indicators for the Report on Government Services compiled by the Productivity Commission. The standards reflect the requirements of the Australian Institute of Health and Welfare and State and Territory community service departments for 2004-05. The data is compiled by each State and Territory and forwarded to the Australian Institute of Health and Welfare.

The scope of the data collection comprises children aged 0-17 years on the following care and protection orders/arrangements (or children aged 18 years who were discharged from those care and protection):

1. Guardianship or custody orders sought through a court, or administrative
arrangements that have the impact of transferring custody or guardianship, including

- Orders where guardianship or custody of a child is transferred to the community services department, another agency or department, or to a third party;
- Permanent care orders; and
- Administrative arrangements or agreements with the community services departments which have the same effect as a court order of transferring custody or guardianship.

2. Supervision and other finalized orders which give the department some responsibility for the child’s welfare, excluding interim orders.

3. Interim and temporary orders including orders that are not finalized, and care applications. The following are excluded from the collection:

- Children on offence orders unless they are also on a care and protection order (as defined above);
- Administrative and voluntary arrangements with the community services department which do not have the effect of transferring custody or guardianship.

Children (age 0-17) should be counted in the State or Territory where the order is operative, regardless of where the child is residing. Only those care and protection orders/arrangements defined in ‘Scope and Coverage’ are included in this collection.

- Family group homes

- Residential child care single dwelling establishments which have as their main purpose the provision of substitute care to children. They are typically run like family homes, have a limited number of children who eat together as a family group and are cared for around-the-clock by resident substitute parents. Family group homes are regarded as residential care.
- Foster care (Foster parents’ are chosen from a list of persons registered licensed or approved as foster parents by an authorized department or non-government organization). The authorized department or non-government organization)

The categories of living arrangements are:

(a) Residential care — where the placement is in a residential building whose purpose is to provide placements for children and where there are paid staff.
(b) Family group homes — provide short term care in departmentally owned homes for children under Care and Protection Orders and other
children whose parents are unable to provide for their immediate welfare. Family Group homes do not have salaried staff but are available rent free to those approved, who receive board payments to reimburse them for the cost of looking after the children in their care.

(c) Home-based out of home care — where placement is in the home of a caregiver who is reimbursed for the cost of care of the child including:
   i. Relatives or kin who are reimbursed (other than parents) by the State/Territory for the care of the child;
   ii. Foster care—where the caregiver is authorized and reimbursed by the State/Territory for the care of the child (excludes relatives/kin who are reimbursed);
   iii. Other home-based care out of home care.

(d) Family care — including:
   i. Parents - (natural or adoptive)
   ii. Relatives or kin who are NOT reimbursed (other than parents).

(e) Independent living — including private board and lead tenant households.

(f) Other living arrangements — including living arrangements that don’t fit into the above categories and unknown living arrangements.

Children in out-of-home care

National data on children in ‘out-of-home care’ are required for both the Australian Institute of Health and Welfare’s publication Child Protection Australia and for the Report on Government Services compiled by the Productivity Commission. The standards reflect the requirements of the Australian Institute of Health and Welfare (AIHW) and State and Territory community services departments for 2004–05. The data are compiled by each State and Territory and forwarded to the AIHW.

The collection includes all children in ‘out-of-home care’ during the year ended 30 June 2005, as well as children admitted to care and children exiting care in 2004-05.

‘Out-of-home care’ is defined as out-of-home overnight care for children aged 0-17 years, where the State makes a financial payment. This includes placements with relatives (other than parents) where the State makes a financial payment. Children who are living with their parents are excluded from this collection. It should be noted that children in ‘out-of-home care’ include children in both legal and voluntary placements.

The collection does not include placements made in disability services, psychiatric services and juvenile justice facilities, or in overnight child care services. Children in SAAP placements are not included.
Description of Databases

University of Western Australia (UWA) School of Population Health
School of Population Health / Research programs / Data Linkage Unit / Population Health Data

The Health Data Collections Branch of Information Collection and Management manages and develops statewide centralized statistical data collections and registers for the Department of Health in Western Australia (WA). The major data collections are listed below. These are housed and maintained at the Department of Health WA.

Several different databases exist:
1. The Hospital Morbidity Data System (HMDS) consists of discharge extracts of all admissions to public and private hospitals in WA since 1970. The reference manual for the above is available in PDF format. The data manager of HMDS can be contacted to assist with interpretation.
   Email: Elisabeth.Sallur@health.wa.gov.au

2. Mortality records comprise all deaths registered in WA by the Registrar of Births, Deaths and Marriages since 1969. Available information includes the date, place and cause of death. A summary of the data fields is available at the website (PDF format).

3. Mental Health Information System (MHIS) contains records of all inpatient contacts and public outpatient contacts with the WA Mental Health system since 1966. The data manager of MHIS can be contacted to assist with access and interpretation of the detailed information available.
   Email: Tom.Pinder@health.wa.gov.au

4. The Cancer Registry (CR) was established in 1981 when mandatory reporting of cancer by pathologists was introduced. The Registry reports on malignancies diagnosed in persons while resident in Western Australia and is managed by a qualified medical officer who can be contacted for further details.
   Email: Tim.Threlfall.

5. Midwives Notification System (MNS) is a register of all hospital and home births in WA since 1980 and is managed by a qualified mid-wife who can be contacted
for further details. Email: Vivien.Gee@health.wa.gov.au

6. Geographical Information. Data sources that incorporate an address field can be assigned as latitude and longitude, collector’s district (CD) and statistical local area (SLA) values using purpose-built address parsing and matching software. Currently the percentages of records that have been geo-coded are as follows; morbidity 85% CD & 90% SLA, mortality 80% CD & 90% SLA and electoral 93% CD & 98% SLA.

A new geo-coding system was developed during 2002 to maximize the assignment of reference points through improved parsing and to assign an area (CD or SLA) where point assignment was not possible. Details of the new geo-coding system and comparisons with previous methods are available here (PDF).

7. School of Population Health / Research programs / Data Linkage
The Data Linkage Unit is a collaboration between the Information Collection and Management Branch at the Department of Health WA, the Centre for Health Services Research at the University of WA, the Division of Health Sciences at Curtin University of Technology, and the Telethon Institute for Child Health Research.

The Unit was established in 1995 to develop and maintain a system of linkages connecting data about health events for individuals in WA. These linkages are created and maintained using rigorous internationally accepted privacy-sensitive protocols, probabilistic matching and extensive clerical review.

The core Data Linkage System consists of links within and between the State's seven core population health datasets, spanning 35 years. The core data sets are: Birth Registrations, Death Registrations, Hospital Separations, Mental Health Clients, Cancer Notifications, Midwives’ Notifications, and Electoral Roll. This is augmented through links to an extensive collection of external research and clinical datasets such as the Maternal and Child Health research data base. (See below)

The establishment and early development of data linkage for health services research is described in Holman et al (1999).

The Data Linkage System consists of chains of links where each link is associated with a record in one of the core data sets. All links in a particular chain have been associated with the same individual through the process of probabilistic record linkage (Newcombe, 1988). This method of linkage relies on the availability of similar demographic information (e.g. name, gender, date of birth, address) in each data source.

Although the Data Linkage Unit’s operations depend on access to personal identifying information derived from each of the contributing data sources, the health details are stored and managed separately.
Monthly updates of morbidity, mortality, cancer, midwives’, births and mental health linkages, and annual updates for ambulance, emergency and Silver Chain linkages, ensure that the linked information in the core data sets remains current.

Electoral roll records were incorporated in April 2000, which helped to resolve some doubtful links as well as providing a sampling frame for research projects. A complete set of electoral roll records was received in March 2001 and updates are now added quarterly. Data can be requested for ethically approved research, planning and evaluation projects which aim to improve the health of Western Australians.

Contact information:
Manager
Data Linkage Unit
Information Collection and Management Branch
Department of Health, WA
Email: dlu@dph.uwa.edu.au

**INDICATORS INCLUDED IN DATABASES**

**Demographics and Vital Statistics**
- Demographic details for each patient (HMDS)
- Birth Registrations (Data Linkage)
- Death Registrations (Data Linkage)
- Electoral Roll (Data Linkage)

**Health**
- Hospital Separations (Data Linkage)
- Mental Health Clients (Data Linkage)
- Cancer Notifications (Data Linkage)
- Midwives’ Notifications (Data Linkage)
- Projected % expected birth weight, actual birth weight (HMDS)
- Hospital administration items (HMDS)
- Medical and clinical information (HMDS)
- Referral and discharge destinations (HMDS)
- Data base on hospital entry filled in by mother (HMDS)
- Gutherie (Apgar like rating) (HMDS)
- Hospital records with full ICD classification of maternal health and Immunization records (HMDS)

**Special Projects, Reports and Initiatives**
WA Cross Jurisdictional Project

The records in the linkage system are derived from morbidity, mortality, midwives, birth, cancer, mental health, and electoral roll records. There can be more than one morbidity record or midwives’ record for an individual, but only one cancer record or mental health record per person.

Some significant health data relating to Western Australia is held by the Australian government. This includes information about residential care and related data concerning aged people, as well as Medicare data which includes pharmaceutical claims in the Pharmaceutical Benefits Scheme (PBS) as well as claims for visits to general practitioners and some other treatments in the Medical Benefits Scheme (MBS). A "best practice protocol" which takes into account privacy concerns as well as enabling data custodians to retain control over the use being made of the information in their care has been developed. This protocol is now being widely used in a number of linkage projects across the country. A formal Memorandum of Understanding (MoU), signed by the WA Department of Health and the Australian Government Department of Health and Ageing covering the cooperation of the two jurisdictions in linking together appropriate data sets enables research and policy analysis for the public good.

Taken from: http://www.sph.uwa.edu.au/research/wadl
**WA Family Connections Genealogical Project.**

The WA Family Connections Genealogical Project was initiated in 2003. The aim is to connect the health history profiles of related individuals through the incorporation of an additional system of linkages that represent genealogical relationships as defined on birth, death and marriage registrations. The two phases are as follows:

- **Phase 1:** Creation of genealogical links from all available electronic registrations (from 1974 for births, 1984 for deaths, and 1984 for marriages).

- **Phase 2:** Encoding and linkage of earlier registrations currently held as paper records.

Research Capabilities

The publication of the sequence of the human genome has advanced prospects for identifying genes responsible for complex disease. The identification of such genes will help to define individuals at risk, improve preventative medicine, and tailor treatments to specific genetic profiles. Understanding the inheritance of complex disease requires the combination of genealogical information and health data. Population-based cohorts considerably improve the estimation of disease risks associated with particular genes. Western Australia, due to its demonstrated record linkage capabilities and recent addition of genealogical properties, is able to make a unique contribution to estimate genetic risk and gene-environment interactions on a population level. The WA Family Connections Genealogy project can be used in combination with the established WA Data Linkage System to support large-scale human genome research.

For further information, contact: email: [Emma.Glasson@health.wa.gov.au](mailto:Emma.Glasson@health.wa.gov.au)
Description of Databases

University of Adelaide: Southern Australia

The Public Health Information Development Unit (PHIDU) is a collaborating unit of the Australian Institute of Health and Welfare located at The University of Adelaide in the Australian Institute for Social Research. PHIDU has been established by the Australian Government Department of Health and Ageing to assist in the development of public health data, data systems and indicators.

John Glover at the PHIDU was the first to map data in Australia in 1990 for the health commission. The maps that appear on the website contain geographic trends for health and some social data. Glover prepared the Social health atlas of Southern Australia. This atlas has census and health but the data is not linked and is simply the populations that pertain to the categories.

Telephone: +61 8 8303 6237
Email john.glover@adelaide.edu.au

Aboriginal and Torres Strait Islander Social Health Atlas, Indigenous Areas, Australia (ATS))

This database contains Indigenous demography and socioeconomic status (1996 and 2001). These data bases contain numbers of individuals in the categories solely. 0-4; 5-14: 15-24; 25-44; 45-64; and 65+ years old.

INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Single parent families with dependent(s) (ATS)
- Low income families
- Jobless families with dependent(s), 2001(ATS)
- Unemployment 1996-2001 (incl. CDEP) (ATS)
- Unskilled and semi-skilled workers 1996-2001(ATS)
- Female labor force participation 1996-2001(ATS)
- Full-time participation in secondary school education at age 16 (1996-2001)
Use of the Internet at home, 2001 (ATS)
Dwellings rented from the government housing authority 1996-2001 (ATS)
Total fertility rate, 2000 to 2002; 2003 to 2005 (ATS)
Indigenous deaths (0 to 74 years), 2001 to 2004 (all causes: total; males; females) (ATS)
Indigenous deaths (0 to 74 years), Circulatory system diseases (ATS)
Indigenous deaths (0 to 74 years), Cancer (ATS)
Indigenous deaths (0 to 74 years), Respiratory system diseases (ATS)
Indigenous deaths (0 to 74 years), External causes (ATS)
Community service orders (ATS)
Imprisonments (ATS)
Single parent families (2001) (ATS)
Low income families (2001) (ATS)
Unemployment (incl. CDEP) (2001) (ATS)
Unskilled and semi skilled workers (2001) (ATS)
Community service orders, 2002-03: total, assaults, traffic (2002-2003) (ATS)
Imprisonments 2002-03: total; assaults; traffic (2002-2003) (ATS)
Female labour force participation (2001) (ATS)
Dwellings rented from SAHT (2001) (ATS)
Use of the Internet at home (2001) (ATS)

Health

Smoking during pregnancy Hospital admissions (ATS)
Hospital admissions, 2002-03 (by principal and all diagnoses) (ATS)

- Diabetes Type 2 (2002-2003)
- Renal failure (all diagnoses only) (2002-2003)
- Substance use related (all diagnoses only) (2002-2003)
- Tobacco use related (all diagnoses only) (2002-2003)
NEW-ZEALAND AND FIDJI DATABASES
New Zealand National Databases

NZHIS:  [www.nzhis.govt.nz](http://www.nzhis.govt.nz)
Child Care and Education:  [www.educationcounts.govt.nz/home](http://www.educationcounts.govt.nz/home)

Description of Databases

The New Zealand Health Information Service (NZHIS)

NZHIS is a group within the New Zealand Ministry of Health responsible for the collection and dissemination of health-related data. From the data it has available, NZHIS is able to supply anyone who needs it with detailed and official information about the health of the country’s population. A number of statistical publications are produced each year, and more immediate provisional information is given in the health statistics section of this site. The types of data collected pertain more to Maternity, Mortality etc. Publications from NZHIS include Publicly funded hospital morbidity data; Private hospital morbidity data; Mental Health service use data; Cancer registrations and deaths; Mortality and demographic data; Fetal and infant deaths; Maternity; Selected health professionals

Education Counts:

The goal of Education Counts is to increase the availability and accessibility of information about education statistics and research. This database also includes some information on child welfare data. Education Counts can be considered a 'one-stop shop' for such information, including:

- Demographic information, specifically tailored for use in the education sector
- Contextual information, such as labour market information, for assisting with the interpretation and understanding of education information
- Reference lists, including address and service details of New Zealand’s education institutions
- Statistical information, various collections of statistical information obtained through Ministry of Education processes, including data on achievement, participation, and resources
- Analysis of education information, including education sector indicators and detailed examination of key education themes
- Publications, such as research and evaluation, Iterative Best Evidence Synthesis, regular monitoring reports, and specialised analysis
• Pathways to other Ministry of Education, and Ministry sponsored, websites

• Technical info to support the use and interpretation of data and information, including data dictionaries, glossaries, and descriptions of analytical techniques.

Information is collected at a regional level (as well as within Maori communities) and passed onto the national government databases.

**INDICATORS INCLUDED IN DATABASES**

**Education and Child Care**

➢ Education and Learning: This domain covers the 'results' of the education system. Results include the skills, knowledge, attitudes, and values gained through the education system. [www.educationcounts.govt.nz/indicators/education_and_learning_outcomes](http://www.educationcounts.govt.nz/indicators/education_and_learning_outcomes)

➢ Student Participation: This domain looks at who has access to the opportunity to learn, and who is enabled to take up the opportunity (including early childhood education). [www.educationcounts.govt.nz/indicators/student_participation](http://www.educationcounts.govt.nz/indicators/student_participation)

➢ Family and community factors influence access to education opportunities, the likelihood of participating in education, and equity of achievement and qualifications. [www.educationcounts.govt.nz/indicators/family_and_community_engagement](http://www.educationcounts.govt.nz/indicators/family_and_community_engagement)

➢ Effective teaching looks at teaching and educator factors associated with the quality and effectiveness of learning. [www.educationcounts.govt.nz/indicators/effective_teaching](http://www.educationcounts.govt.nz/indicators/effective_teaching)

➢ Quality Education Providers: The focus here is on the management and governance efforts that are applied to the resources in the sector to produce desired outcomes. [www.educationcounts.govt.nz/indicators/quality_education_providers](http://www.educationcounts.govt.nz/indicators/quality_education_providers)
Fiji Databases

Health:  [www.health.gov.fj](http://www.health.gov.fj)

Description of Databases

No information is collected at the regional level. There are four administrative divisions: central, eastern, northern and western, each of which are under the charge of a commissioner. Ethnic Fijians have their own administration in which councils preside over a hierarchy of provinces, districts, and villages. However, health and data population matters are dealt with at a national level.

**Fiji National Databases**
The census is currently the only source of population data in Fiji. The last data was collected September, 2007 and data is not available at this time but a national census is scheduled for every 10 years.

**Education Databases**
In July 2007, the Ministry of Education intensified its efforts to provide Early Childhood assistance to communities in remote and disadvantaged areas. The Ministry of Education initiated the setting up of the Early Childhood, Care, Development and Education Affirmative Action Programme [ECCDE – AAP] Taskforce. The taskforce is assigned the task of formulating an Action Plan for Early Childhood Education for Fiji. Funds have been distributed to various schools.

**Health Databases**
The PATIS (Patient Information System), last updated in 2002) which is a new computerized health information system with its software developed in Australia through the Fiji Health Management Project a bilateral project between the Fiji and Australian governments. First implemented in Samoa and gradually extended to other areas. The full extent of coverage is not clear from the website.

PATIS registers all people having an occasion of service in the health system. All those registered get a unique national health number and those over 15 years of age get a health card. You can now track the service that a patient is getting through this number. Those less than 15 years of age get linked to an adult who may be a parent or guardian and do not get issued a card. The national health number is also used to file medical records and has helped in consolidating medical records and in tracking of medical records. To implement PATIS 24 hrs electricity supply and telephone lines and cabling for computers is required.
Information can be accessed at facility level, medical area level, sub-divisional level, divisional level and national level. Quality and accuracy of data is ensured through in-built checks and through regular checks by assigned system administrators. A list of reports that can be generated through simple statistical analysis by PATIS is said to available on-line, although no links to this were found on the website.

**Special Projects, Reports and Initiatives**

**The Central Information Centre (CIC)**


In 2004 the Office of the Prime Minister undertook the development of a central database to help facilitate planning of development programmes and projects. The Central Information Centre (CIC) (created in 2002) will contain information on a regions' provinces' socio-economic activities, income, demographic details, development indicators, development programs/projects and resource capabilities. This is designed to enable Government to better target development activities and projects according to the resource capabilities of each province and region and their most pressing needs and priorities. CIC will be developed to contain, on a regional, provincial, tikina, village and locational basis information on population, access to basic needs, goods and services, development projects, development potential, development constraints, household income, educational levels, and social capital etc.

**Early childhood health care and education program (UNICEF)**


The program's goal is to target rural areas. Since 1998, government has provided to the 468 recognised ECE learning centres which serves 6,900 children in the following ways:

- Salary grants
- Building funds
- Materials - teaching and learning resources, etc.

Recognized ECE learning centres are those that have followed government guidelines for such centres. There are no national guidelines regarding curriculum but there are operational and procedural guidelines for the establishment and operation of preschool centres. Those preschools that follow these guidelines are eligible for salary grants and other support from government. However, only around 6,900 children attend these schools. The government is encouraging private organizations to develop and manage preschools. It is clear that the
Ministry is not yet prepared to assume greater responsibility for this level of education and has a hands-off approach in allowing the continuing growth of all types of ECE centres. A parenting component of the ECE project is being created that addresses child health and nutrition; there is no information available on this component.
LATIN
AMERICAN
DATABASES
Organization of the American States

www.oea.org
www.coordinacion.oea.org

Please see information for this database under “global databases”

Organización des los Estados Iboamericanos (OEI)

www.oei.es/quipu

Please see information for this database under “global databases”
Colombia

No ECD databases available on-line

Special Projects, Reports and Initiatives

Early Childhood Policy Project

Purpose: The purpose of this project is to examine the design and implementation of the monitoring and evaluation system of the Early Childhood Policy in Colombia.

In 2006, Colombia finalized the design of the project. Its main objective is to guarantee the rights for the development and quality of life for children between 0 and 6 years old, the pregnant mothers and their families. The Policy of Early Childhood has been conceived as a collaboration between State and society. From this perspective, the fulfillment of the rights of early childhood is not a subject that concerns only the State, but family, State and society.

To verify the fulfillment of this proposed objective, periodic evaluation of processes is necessary, in order to know the conditions of the early childhood at national, provincial and local levels. To this end, it is necessary to have opportune and complete information from institutional historical series, information systems, population surveys, longitudinal studies, depth studies in specific subjects and impact evaluation, among others sources.

Project development:
With the support of the Embassy of Canada in Colombia, the ICBF will lead the design and implementation of the monitoring and evaluation system of the Early Childhood Policy in Colombia. For this purpose, the ICBF will establish an alliance of technical support with a Canadian organization specialized in evaluation of public policies and development in the early childhood.

A) Levels for the evaluation: National, provincial, and local levels

B) Lines of Enquiry

1) Evaluation of necessities: It looks for the identification and analysis of the general context of the country and the changes in the situation of the early childhood, under an approach of rights and the specific objectives of the Policy.
2) Evaluation of social results of the Policy: It includes: a) Monitoring of the changes in the development of the population group, from survival indicators (health and nutrition) and development indicators (knowledge, emotional and social), b) The fulfillment of the goals defined in the National
Plan of Action in Favor of the Early Childhood according to policy objectives, objectives of the national, provincial and local programs directed to early childhood, services directed to promote the guarantee of the rights in the different levels and management of the public and private financial resources. The system requires at least one annual update in its different components.

C) Expected results:
Once executed the Project the country will have a System of Monitoring and Evaluation of Early Childhood Policy, that will allow all partners of the Project, and others related with the supply of services and social control, to have information on:

- National and provincial conditions of early childhood.
- National context and its incidence in early childhood.
- Results of the objectives proposed in national and departmental programs.
- Results and advances by objective of the policy.
- Public and private supply of attention of the early childhood.
- Development index of the early childhood in Colombia.
- Results of national and international investigations on early childhood.
- International virtual contact with institutions related with the System subject.

E) Activities:

1. To make a first approach between the Canadian associate organization, the ICBF and the other organizations to start the technical assistance. It includes exchange of information and meetings to know the Early Childhood Policy and the situation of this population in Colombia and Canada.
2. To elaborate the first draft of approach by the Canadian associate organization, with an approximation to an Evaluation System for the Early Childhood Policy in Colombia. It includes conceptual approach, operative mechanisms and general structure of the system, national institutions and basic conditions to the management of the evaluation process.
3. To discuss the content of the document of approach by levels (national, provincial and local), in order to complement the population characteristics and the advances of Colombia in the Early Childhood Policy implementation.
4. To elaborate the first draft of the system of evaluation by the Canadian associate organization.
5. To elaborate the plan of qualification in monitoring and evaluation by the Canadian associate organization, directed to the operators and other national organizations that take part in the evaluation of the Policy.
6. To discuss the first draft with decision takers and experts at national, provincial and municipal level.
7. To design the first stage for the start up of the System.
8. To start up the qualification plan.
9. To start up the system of monitoring and evaluation of the Policy.
10. To evaluate the operation of the system.
11. To implement the system all over the country.
12. To offer support to the System operators.

F. Benefits for the associate organization:
The Canadian associate organization will benefit widely in several aspects such as:
- Specialization of its experience in the design of evaluation systems in developing countries.
- Access to the data bases of the National Survey of the Nutritional Situation ENSIN 2005, made by the ICBF.

This survey studied the prevalence of the nutritional problems and food consumption that affects to the Colombian population between 0 and 64 years of age, by means of the evaluation of the nutritional, anthropometric and biochemical indicators, breast feeding and complementary feeding, dietetic ingestion; qualitative evaluation of the feeding security, physical activity, dedicated time to watch TV and to play with video games, auto- perception of the corporal weight and associated conducts, and auto - report of Mellitus Diabetes and arterial hypertension.

It is a survey of homes that has a national cover with urban and rural representation (6 regions and 14 sub-regions). The most of the indicators was obtained provincial representation.

This survey has been considered by international experts as the high quality study and technical level of Latin America. This information can be very useful for its scientific investigations and articles, to make comparisons with other countries and the nutritional situation at world-wide level. Finally, for universities it is an important source for doctoral thesis development.
Mexico

Demographics and Vital Statistics: [www.conapo.gob.mx](http://www.conapo.gob.mx)

Description of Databases

**Sistema de Seguimiento de la Situación de la Infancia y Adolescencia (SISESIA)**

The only system of indicators of childhood and adolescence that exists in Mexico is The Tracking System of the Status of Children and Adolescents (SISESIA), an effort by the Mexican government to introduce indicators that will track the goals of the UNICEF Program of Action for Children (PAFI) 2002-2010, and report on the status of children and adolescents in Mexico.

Caveats for these SISESIA databases

Indicators that relate to rates and fees, only show the percentages with no access to the raw numbers. The indicator must be accompanied by the necessary data to understand a situation in a comprehensive manner. This limits the use of an indicator. A second issue relates to the lack of a measure of variability. This is a flaw in the widespread indicator systems. Averages tend to hide differences. There also are some indicators that are not clearly defined as to the population to which they relate; one does not know the total number of children in poverty for example and this is not given in the data sheet that can be downloaded.

It is understood that some sources are surveys that have not been designed for the purpose to which they are put and for this reason, the desired breakdown of age is absent. In general the age breakdowns are adults and children age 18 and under. There are areas where there is no information, such as child abuse.

Advantages of these SISESIA databases

There are several features such as incorporating data sheets, and a technical page for each indicator which provides information as to how an indicator is calculated that make the site easier to use. Sources of data is provided whenever possible. The accessibility of data is an advantage in that the person using the system tables can download them in Excel but again raw data is not available on the website making its utility somewhat limited.

**INDICATORS INCLUDED IN DATABASES**

**Demographics and Vital Statistics**

- Total population of children (not broken out by age)
- Average annual growth rate of children and adolescents (not broken out by
Life expectancy at birth - Ministry of Labor and Social Security (STPS)

Percentage of births registered in the first six months of age - National Institute of Statistics, Geography and Informatics

Percentage of households with children - National Survey of Employment and Occupation

Percentage of households with children and adolescents who occupy homes without water service - National Institute of Statistics, Geography and Informatics

Percentage of households with children and adolescents who occupy homes without sewer service - National Institute of Statistics, Geography and Informatics.

- Ministry of Labor and Social Security (STPS)  www.stps.gob.mx

Mortality rate of children under 1 year as registered.


Mortality rate of children under 5 years: Registered;


- Ministry of Health(www.salud.gob.mx)

Education and Child Care

- Gross enrollment in preschool education (4 to 5 years)
- Gross enrollment in primary education (4 to 15 years);
- Index of gender equality in preschool education.
  - Released by the Secretariat of Public Education (www.sep.gob.mx/wb2). Most data is for ages 6-15. The above are examples of indicators.

Health

- Mortality rate of children under 5 years by diarrheal diseases
- Mortality rate among children under 5 years for respiratory infections
- Vaccination coverage with basic outline comprehensive population one year of
Prevalence of malnutrition in children under five years
Cases of tuberculosis meningeal in children under age 5
Percentage of births with low birth weight
New cases of AIDS perinatal transmission - Directorate General of Epidemiology
Prevalence of HIV/AIDS in pregnant women
Percentage of pregnant women diagnosed with HIV/AIDS, receiving treatment for the reduction of maternal and infant transmission.
  • Healthy Life data are released by the Ministry of Health unless otherwise noted. (www.salud.gob.mx). The above are examples of indicators.

Child Welfare

  • Proportion of children under 5 years who received nutritional supplement from the Opportunities Program as part of the children in Poverty Food;
  • Percentage of children under 12 years old who are beneficiaries of the program Abasto Social Milk as part of the children in Poverty Food
  • Poverty and Children - the data are released by the Ministry of Social Development (www.sedesol.gob.mx/index/index.php). Most indicators are for children under 18 years of age and not broken out by age

Special Projects, Reports and Initiatives

The National Survey of Health and Nutrition 2006

(ENSANUT 2006)

This project unifies the content of the surveys of nutrition and health, creating an unprecedented database, which allows addressing the problems of malnutrition and epidemiological backwardness, which are particular to the most marginalized people in Mexico. The ENSANUT 2006 expanded its coverage to achieve for the first time representation from each of the states. This feedback will enable decision-making in health, nutrition and social development at the state level.

The ENSANUT 2006 includes the study of prevalence of some chronic and infectious diseases, the perception of the public about the quality and the response of the state health system, the socio-demographic characteristics of household expenditures incurred in a catastrophe as a result of the impairment of health. In addition, the study of the impact on health of opportunity programs such as Equal Start In Life, Sedesol, the distribution of supplements with vitamins and minerals to vulnerable children and women are included
The ENSANUT 2006 coincides with the start of operations of CONEVAL and will undoubtedly provide important input for the evaluation of social development policies aimed at improving health and nutrition of the population.

The conceptual framework of the ENSANUT 2006 was designed not only to be about the health of Mexicans, but also about the challenges of access to health and social protection. It defined the challenges of equity, quality, financial protection and health as a decline in the prevalence of diabetes mellitus, hypertension, hypercholesterolemia and obesity and an increase in health benefits and immunization coverage.

One of the immediate conclusions of the current survey is that there has been progress in the coverage of health services, as part of the Social Protection System in Health, whose action has mainly benefited the households living in extreme poverty.

Methodology
Methodology featured probabilistic sampling by stratified clusters and face-to-face interviews in the home. The questionnaire applied to children captures data about their general state of health including vaccination, diarrheal disease, acute respiratory infections, asthma and accidents. In addition, some subjects were selected by the health and nutrition team for each age group team for a blood sample to determine the concentration of hemoglobin, a blood pressure reading, and anthropometric measures (weight, height or length and waist circumference).

For women who have given birth during the past five years, questions were asked on the weight of children at birth, regardless of whether they had survived or died.

In addition, a questionnaire on food aid programs in the family were asked for those selected subjects whose families had benefited from the Opportunity Program and the Social Milk Supply Liconsa.

Measures in ENSANUT 2006, are listed as follows:

- State of nourishment of children and adults in Mexico
- State of health of the Mexican population and the prevalence of certain chronic and infectious diseases
- Perception of the public about the quality of the health system in the State
- Perception of the public about the response of the health system in the State
- Socio-demographic characteristics of households who incur an expense as a result of the impairment of the health of their members.
- The impact on health Opportunities Program (Opportunities)
- The information gathered at the state level distinguish characteristics of the population as urban and rural distribution, four tiers of income, and age groups (children, school children, adolescents, adults and seniors).
- Children are people from home between 0 and 9 years of age
- Adolescents are people in the household who are in the group
- Age 10 to 19 years
• Adults are people in the household older than 19 years

The use of health services including immunization, baby visits, family planning, pregnancy care & testing, dental services, obtaining medical care, talks of health education, and control program for Diabetes or Hypertension

Indicators for Children 0-9
• Positive indicators and risk factors
• Vaccines
• Diarrheal Disease
• Acute respiratory infections and asthma
• Accident
• Practice of nursing
• Supplementary Feeding (<2 years)
• Diet (1-9 years)
• State of nourishment was assessed using anthropometric indices built on the basis of measurements of weight, height and age. The three indicators used were weight weighted for age, height expected for the age and weight expected for height.
• Weight and height
• Blood Capillary
• Venous blood (1 to 9 years)

National System of Health Surveys (SNES)

Since the establishment of the SNES, launched 20 years ago in Mexico, there has been a great systematic effort to obtain relevant and accurate information about the health conditions of the population and the performance of the National Health System through the design, implementation, evaluation and reorientation of actions and policies. This goal was ratified in the National Development Program 2001-2006, and specifically as the National Health Program 2001-2006. SNES, has developed more than 20 national probability surveys with the aim of obtaining regular information on the nutrition and health conditions of the Mexican population and of the performance of the National Health System.

Between 1999 and 2000 the different surveys were grouped into two major themes: Nutrition 1999, whose purpose was to study the state and nourishment of children and women of childbearing age, as well as of social policies and programs aimed at improving food and nutrition of marginalized people; and the National Health Survey 2000, which dealt with health conditions and the performance of the National Health System.
The Latin American Project

Led by Ferran Casas of Spain and funded by Child Watch International a new project is emerging in Latin America that serves as an umbrella for groups listed below. Its first meeting took place on July 2002 in Costa-Rica and was hosted by the Paniamor Foundation (a Key Institution of CWI in Costa Rica).

www.childwatch.uio.no

Centro de Investigaciones para Infancia y Familia (CENDIF)

Centro de Investigaciones para la Infancia y la Familia (CENDIF)
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Director: María Angélica Sepúlveda
Since 1995 the Centre for Infancy and Family Research at Universidad Metropolitana, Caracas, has set itself the challenge of finding new ways to support the development of holistic, non-conventional programs for children and families in marginalized urban sectors in the country based on sound research. CENDIF mission is: research, teaching on the design, production and evaluation of models of intervention in the area of human development of socially disadvantaged families and communities to enhancing their quality of life. Nowadays, CENDIF develops through a direct and participatory agreement with community organizations, global and systemic programs directed to children from 0-6 years of age and adolescents from 7-17, their families and the community in the areas of health, children's rights, nutrition, non conventional education, legal orientation, community development, environmental education and recreation.

Other CENDIF objectives are:
- To offer training to policymakers and coordinators of child and family programs.
- To provide supervision for graduate and postgraduate research.
- To develop collaborative research across countries to better understand how children, youth and families perceive their environment and opportunities of development that might serve to develop policy and programs.
Today, CENDIF has facilities for graduate and postgraduate research, data processing equipment, reproduction equipment and a small documentation centre provided with some 2,000 documents with emphasis on Latin America. It receives apprentices from national and international Universities. CENDIF’s staff has 8 years of experience implementing research-action programs with mothers and children affected by the imprisonment of their mothers. Many international conferences have been dedicated to this issue. An important feature of its work is the preparation, publishing and validation of educational materials for training.

International Center for Research and Policy on Childhood (CIESPI)

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Mission: To improve the condition of low-income children in Brazil, particularly children in urban low income areas, including the slums, through applied research, policy and project development and training. This is a non-profit research center dedicated to applied research, policy analysis and training about the needs of children, particularly disadvantaged children, and their families. Activities include: Research and Social Policy Projects, Interdisciplinary Training for Students and Professionals, Resource Center, Project Consultation and Print and Electronic Publications.

CINDE - The International Center for Education and Human Development

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CINDE is an educational research and development center, with headquarters in Colombia and with local, national and international projection. Their central focus is the creation of appropriate environments for the healthy physical and psychosocial development of young children. Areas of work are social and educational programs focused on the healthy development of young children and development of human talent at all levels: community, institutional, specializations (Master and doctoral programs). CINDE has two research groups recognized by Colciencias, the Colombian Institution that foster research in social and natural sciences Integral Development of Childhood and Youth. CINDE has the research component in all areas of work, but a great deal of research is done through the graduate programs: master degrees and doctoral program.

Centro de Documentación Sobre Infancia

"Dr. Joaquin Cravioto" Programa Infancia, Universidad Autónoma Metropolitana Documentation Center on Infancy and Childhood "Dr. Joaquin Cravioto" Research Program on infancy

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An interdisciplinary research and academic university program on Infancy created in 1999. Members of the 3 campuses have created networks with local, national and international organisms which work with the most vulnerable sectors (migrants, indigenous, special needs children) and are committed to the promotion of policy, legal and juridical changes consistent with the Convention of the Rights of the Child. The documentation Center collaborates with a Latin American informational network. It coordinates an Iberoamerican network on Education courses and programmes to change the paradigm on infancy coherent with the Convention on the Rights of the Child. Lines of Interdisciplinary Research include:

- Disability and Childhood (early detection of hearing loss, inclusion, early intervention, Toy Construction and design Workshops with parents and children, design of technical aides for rehabilitation);

- Education and Communication: Child Participation in their community using
artistic and play techniques; Technology in basic education as a means to promote writing in indigenous languages, intercultural education and mainstreaming children with special educational needs.

- Law and Politics: Workshops with judges, magistrates and with congressmen on applying the Convention of Child Rights in legal sentences and family legal issues.

- Elaboration of proposals to make the necessary reforms in the Local Laws to actualize the Convention of Child Rights.
AMERICAN DATABASES
Description of Databases

The US has seen an expanded interest among the pediatric health policy and practitioner communities in moving beyond narrow medical models of health to promote more broadly the development of very young children including their social, emotional, intellectual, and physical well-being. To this end, more effort has been put on developing indices of child health and well being including children and communities school readiness.

Administration for Children, Youth and Families (ACYF): Annual reporting on Head Start (Head Start)
There is excellent administrative/program data on the sole American national ECEC program - Head Start. Data is collected on every Head Start program as well as on every child and family accessing it. Details on program characteristics, costs, characteristics of children enrolled, type of sponsoring agency, geographic region, and projections of costs and enrollment are collected by Head Start and compiled in a variety of ways. Head Start also produces annual fact sheets. For example, Facts on Head Start Budgets reports the enrollment of children, their ages, race/ethnicity, state allocations, enrollment and appropriation history.

National Vital Statistics System, the National Center for Health Statistics (NCHS)/ Birth Certificate Data, Vital Statistics System
This is one of the few sources of data on young children available at the local level throughout the U.S. It provides important data on health factors and practices known to be related to later intellectual and socio-emotional development including birth weight, breastfeeding, and parental educational attainment. It also collects and publishes data on births and deaths in the United States. NCHS obtains information on births and deaths from the registration offices of all States, New York City, and the District of Columbia. Demographic information on birth certificates, such as race and ethnicity, is provided by the mother at the time of birth. Hospital records provide the base for information on birth weight, while funeral directors and family members provide demographic information on death certificates. Medical certification of cause of death is provided by a physician.

National Linked Files of Live Births and Infant Deaths (NLF)
The National Linked File of Live Births and Infant Deaths is a data file for research
on infant mortality. Beginning with the 1995 data, this file is produced in two formats. The file is released first as a period data file and later as a cohort file. In the birth cohort format, it includes linked vital records for infants born in a given year who died in that calendar year or the next year, before their first birthday. In the period format, the numerator consists of all infant deaths occurring in one year, with deaths linked to the corresponding birth certificates from that year or the previous year. The linked file includes all the variables on the national natality file, as well as medical information reported for the same infant on the death record and the age of the infant at death. The use of linked files prevents discrepancies in the reporting of race between the birth and infant death certificates. Although discrepancies are rare for White and Black infants, they can be substantial for other races. National linked files are available starting with the birth cohort of 1983. No linked file was produced for the 1992 through 1994 data years. Match completeness for each of the birth cohort files is about 98 percent.

Decennial Census Data
www.census.gov/population/www/Every 10 years, beginning with the first census in 1790, the United States government conducts a census, or count, of the entire population as mandated by the U.S. Constitution. In 2000, as in several previous censuses, two forms were used—a short form and a long form. The short form was sent to every household; the long form, containing the 100 percent questions, plus the sample questions, was sent to approximately one in every six households. The Census 2000 short form questionnaire included seven questions for each household: name, sex, age, relationship, Hispanic origin, race, and whether the housing unit was owned or rented. The long form asked more detailed information on subjects such as education, employment, income, ancestry, homeowner costs, units in a structure, number of rooms, plumbing facilities, etc. Decennial censuses not only count the population but also sample the socioeconomic status of the population, providing a tool for the government, educators, business owners, and others to get a snapshot of the state of the Nation. A more comprehensive description of Census 2000 is available at: www.census.gov/mso/www/c2000basics.

The Census Bureau attempts to control the sources of such error during the data collection and processing operations. The primary sources of error and the programs instituted to control error in Census 2000 are described in detail in Summary File 1 Technical Documentation in Chapter 8, “Accuracy of the Data,” located at: www.census.gov/prod/cen2000/doc/sf1.pdf

Pregnancy, Nutrition Surveillance System (PNSS)
www.cdc.gov/pednss/This is collected annually in selected states. It covers pregnant and post-partum women participating in federally funded public health programs. Data is collected on low-income pregnant women participating in federally funded public health programs including WIC and MCH. PNSS data represent approximately 750,000 pregnant and postpartum women. These surveillance systems provide data that
describe prevalence and trends of nutrition, health, and behavioral indicators for mothers and children. Data collected include maternal smoking and drinking during pregnancy, anemia, diabetes, hypertension, maternal weight gain, medical care, and multivitamin consumption.

**Pediatric Nutrition Surveillance System (PedNSS)**
[www.cdc.gov/pednss/](http://www.cdc.gov/pednss/)
Data is collected annually in selected states. It covers children ages 0-5 attending federally funded maternal and child health nutrition programs. PedNSS data represent more than 7 million children from birth to age 5. It follows the nutritional status of children ages 0-5 in federally funded maternal and child health and nutrition programs including WIC, EPSDT, and the Title V Maternal and Child Health program (MCH). Data collected include birth weight, under- and overweight, anemia, and breastfeeding.

**National Child Abuse and Neglect Data System (NCANDS)**
[www.acf.hhs.gov/acf_services.html#caan](http://www.acf.hhs.gov/acf_services.html#caan)
This is a primary source of data on child abuse and neglect in the U.S. The indicators are strongly related to negative early child development outcomes. Data is collected annually as case-level data on reports alleging child abuse and neglect, and the results of these reports, from State child protective services (CPS) agencies. It covers children ages 0-21. The mandate for NCANDS is based on the Child Abuse Prevention and Treatment Act (CAPTA), as amended in 1988, which directed the Secretary of the Department of Health and Human Services (HHS) to establish a national data collection and analysis program that would make available State child abuse and neglect reporting information. During the early years, States provided aggregated data on key indicators of reporting of alleged child maltreatment. Starting with the 1993 data year, States voluntarily began to submit case-level data.

Beginning in 2000, the case-level data set became the primary source of data for the annual report. States that submit case-level data construct a child specific record for each report of alleged child abuse or neglect that received a disposition as a result of an investigation or an assessment during the reporting period. The case-level data are reported in the Child File. Data fields include the demographics of the children and their perpetrators, types of maltreatment, investigation or assessment dispositions, risk factors, and services provided as a result of the investigation or assessment. In 2004, forty-five States submitted the Child File; almost all of them also reported aggregate-level data in the Agency File for items that were not obtainable at the child level, such as the number of CPS workers. Five States reported only aggregate statistics on key indicators; four of these States are in the process of developing the Child File.

The count of child victims is based on the number of investigations that found a child to be a victim of one or more types of maltreatment. The count of victims is, therefore, a report-based count and is a “duplicated count,” since an individual
child may have been the subject of a report more than once. Children are considered to be “victims of maltreatment” if the allegation is either “substantiated” or “indicated” by the investigation process. Substantiation is a case determination that concludes that the allegation of maltreatment or risk of maltreatment is supported by State law or policy. “Indicated” is a case determination that concludes that maltreatment cannot be substantiated by State law or policy, but there is reason to suspect that the child may have been maltreated or was at risk of maltreatment. The available data lacks any measures of intellectual or socio-emotional development. Rates from 2000–2005 are based on case-level data submitted by the States. 52 States reported case-level data in 2005 and 51 States reported on age of victim in 2005.

Information about NCANDS is available on-line at the web sites listed above:

Adoption and Foster Care Analysis and Reporting System (AFCARS)  
www.acf.hhs.gov/programs/cb/systems/index.htm
The Adoption and Foster Care Analysis and Reporting System collects case level information on all children in foster care for whom State child welfare agencies have responsibility for placement, care or supervision, and on children who are adopted under the auspices of the State's public child welfare agency. Data is collected continuously nationally and in states. It covers ages 0-19 in the foster care system. Follows children in the adoption and foster care systems, but offers no data on the health and development of children in those systems.

Individuals with Disabilities Education Act Data (IDEA)  
www.disability.gov/education  
Data is collected continuously nationally and in states for the IDEA database. It covers ages 0-21. Administrative data on children with disabilities who are served through the Individuals with Disabilities Education Act (IDEA) are included. Data are collected for children ages 3-5 and 3-21. These are aggregate data reported by the states. Data include number of children receiving services, type of service, type of disability, the educational environment, discipline, and exits from special education.

KIDSCOUNT  
www.kidscount.org/sld/db_definitions.jspn
The system of indicators for children KIDSCOUNT is in the 50 states of the United States and Puerto Rico. This system is organized or sponsored by the Annie E. Foundation Casey. In every state there is an organization allied with Annie E. Casey, who is responsible for issuing the reports of the state. Each year, a report is issued for the Nation as a whole, showing figures by state and place or rank of each state regarding the set of indicators. Each state has developed its system of indicators, according to their information needs and available data. The KIDSCOUNT, national is based on a set of 34 indicators that are homogeneous in all States. Apart from the national report, each KIDSCOUNT issues its reports. This information is accompanied by text explaining the context of the problem and interpretation of data, which distinguishes this system from others.
The conceptual framework of KIDSCOUNT stipulates certain criteria for the inclusion of data in the system:

A) The data must be from a trusted source.
B) The statistical indicator should be consistent in time and there should be access to it. No measures are recommended whose methodology changes over time.
C) The indicator must be consistent in all states and there should be access to it at all States.
D) The indicator must reflect an outcome or a welfare measure. It focuses on data not programmatic services.
E) The indicator must be easily understood by the general public.
F) The indicator should not have ambiguous interpretations.

Annie E. Casey promotes systems indicators of childhood as a tool to monitor the welfare of children in the United States under the conceptual basis that there are three areas of work in the administration of welfare: Incidence, communication and data. By using strong and accurate data to substantiate the incidence and communicate the needs and the situation facing children, it is called "impact based on data" or data based advocacy.

2-Year-Olds Who Were Immunized 2005
This data is derived from the National Immunization Survey, which provides state estimates of vaccination coverage levels among children ages 19 months to 35 months. The figures given here reflect the percentage of children who have “4:3:1 Series Coverage”; that is, four or more doses of diphtheria and tetanus toxoids and pertussis (DTP) vaccine, diphtheria and tetanus toxoids (DT) vaccine, and diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine; three or more doses of poliovirus vaccine; and one or more doses of measles-containing vaccine.

Sources
• U.S. Centers for Disease Control and Prevention.
• Infant Mortality Rate (deaths per 1,000 live births) is the number of deaths occurring to infants under 1 year of age per 1,000 live births. The data are reported by place of residence, not place of death.
• U.S. Centers for Disease Control and Prevention, National Center for Health Statistics.

Live births weighing less than 2,500 grams (5.5 pounds).

Births of unknown weight were not included in these calculations. For more detail on all reporting issues refer to Definitions, Data Sources, and Reporting Issues for States at: www.kidscount.org/sld/rs_state_def.jsp.

Data Source: Child Trends analysis of 1990-2004 Natality Data Set CD Series 21,
numbers 2-9, 11-12, 14-16 (SETS versions), and 16H and 17Ha (ASCII version), National Center for Health Statistics.

Note: The District of Columbia, Puerto Rico and the U.S. Virgin Islands are not included in maps and rankings because they are not states and therefore comparisons on many indicators of child well being are not meaningful.

Getting Ready (GR)
www.GettingReady.org

The School Readiness Indicators Initiative was a multi-state initiative that uses child well-being indicators to build a change agenda in states and local communities in order to improve school readiness and ensure early school success. The task of participating states was to develop a set of child outcome and systems indicators for children from birth through the fourth-grade reading test, an important red flag for children most at-risk for poor long-term outcomes, such as dropping out of school, teen pregnancy, and juvenile crime. There are three main objectives:

1: To create a set of measurable indicators related to and defining school readiness that can be tracked regularly over time at the state and local levels.
2: To have states and local governments adopt this indicators-based definition of school readiness, fill in gaps in data availability, track data over time and report findings to their citizens.
3: To stimulate policy, program and other actions to improve the ability of all children to read at grade level by the end of the third grade.

The Initiative involved 17 states: Arizona, Arkansas, California, Colorado, Connecticut, Kansas, Kentucky, Maine, Massachusetts, Missouri, New Hampshire, New Jersey, Ohio, Rhode Island, Vermont, Virginia, and Wisconsin. State teams worked individually and as a group to develop a comprehensive set of measures to monitor school readiness and service system outcomes for children and families. Each team consisted of multi-agency senior policy and data staff.

INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Birth information (NCHS)
- Death information (NCHS)
- Linked birth and death files of infant with medical information (NLF)
- Child Deaths Selected State Depts. of Public Health. # of child deaths
per 100,000 children (ages 1-4, ages 5-9, ages 10-14)

- Household data: Name, sex, age, relationship, Hispanic origin, race, and whether the housing unit was owned or rented (Census 2000 short form)

- Household information: education, employment, income, ancestry, homeowner costs, units in a structure, number of rooms, plumbing facilities, etc. (Census 2000 long form)

- Mother’s Education Level (GR)
  - Depts. of Vital Statistics and Public Health for selected states and years. CA (% of children born to mothers with less than 12 years of education - available at the state and county level and by ethnicity - released yearly) KS (% of infants born to mothers with at least a high school degree). ME (Education level of the mother). MA (# of births whose birth mother has a high school diploma, GED or higher). MO (% of births to mothers with less than 12 years of education). RI (% of total births to women with less than a high school diploma). VA (percentage of births to mothers with less than 12th grade education; # of births to a mother with less than a 12th grade education).

Education and Child Care

- Head Start program characteristics, costs, characteristics of children enrolled, type of sponsoring agency, geographic region, and projections of costs and enrollment (Head Start)

- Head Start. Enrollment (GR)

- Early Head Start Enrollment (GR)
  - State Early Head Start Bureau and State Dept. of Social Services for selected states and years. MO (Children in Early Head Start as a percent of children under age 5 in poverty). RI (% of income-eligible children birth to age 3 enrolled in the Early Head Start program). VA (Early Head Start enrollments by grantee; # of children enrolled in Early Head Start).

- Children receiving services, type of service, type of disability, the educational environment, discipline, and exits from special education (IDEA)

- Language Development (GR)
  - Assessed variously in selected states for selected years: MA
(ESL); MO (Percent children at K entry recognizing basic shapes at K entry and using language to communicate ideas, feelings, questions and to solve problems); RI (Verbal fluency and emergent literacy; rate of K children who do not use age-appropriate vocabulary - Depts. of Education & SALT survey); VA (K assessments - Phonological Awareness Literacy Screening; % identified as needing additional literacy intervention); WI (Early learning standards assessment of language development and communication).

- **General Skills and Behaviors (GR)**
  - Years ME (% of kindergarteners who demonstrate developmentally appropriate skills and behaviors (developmental)- Maine Success by Six School Readiness Survey - Single region); MO (% of children almost always coping with failure and frustration at kindergarten entry)

- **Approaches to Learning (GR)**
  - Gathered by Depts. of Elementary and Secondary Education for selected states and years: MO (% of children almost always showing curiosity and interest at kindergarten entry); RI (Inclination to use skills, knowledge and capacities rate of kindergarten students who have a problem with concentrating and paying attention rate of kindergarten students who have difficulty following direction rate of kindergarten students who have trouble working independently).

- **Cognitive Development (GR)**
  - Collected by the Depts. of Elementary and Secondary Education in selected states for selected years: ME (% of children experiencing difficulties in basic academics when arriving at kindergarten - Maine Success by Six School Readiness Survey Single region); MO (At kindergarten entry - % of children almost always recognizing the relationship between letters and sounds & % of children almost always determining “same”, “more than” and “less than” by using comparisons); RI (Knowledge about properties of objects and societal conventions rate of kindergarten students who cannot count objects - Dept. of Elementary and Secondary Education, SALT Survey)

- **Social-Emotional Development (GR)**
  - Collected by the RI Dept. of Elementary and Secondary Education & SALT Survey in RI for selected years: RI (Ability to interact with others; rate of kindergarten students who have difficulty working with others; rate of kindergarten students who are disruptive in class; rate of kindergarten students who are overly aggressive to peers)

- **Physical Well-Being and Motor Development (GR)**
  - Collected by the Depts. of Education, the School Nurse Consultants and Dept. of Health for selected states and years: ME (#
of children entering kindergarten exiting special education to regular education; Sub-indicator visual ability: % of children entering kindergarten with untreated vision problems; Sub-indicator auditory ability: % of children entering kindergarten with untreated hearing problems). MO (% of students with unidentified special needs at kindergarten entry; % of children with age-appropriate fine motor skills at kindergarten entry; % of children with age-appropriate gross motor skills at kindergarten entry); RI (rate of students entering kindergarten with a history of lead poisoning).

- Child Care Licensing and Accreditation (GR)
  - NAEYC and National Association for Family Child Care (NAFCC) as well as Dept. of Human Services for State. Collected for selected states and years. AZ (% of licensed child care centers that are NAEYC accredited). KY (# of accredited centers; # of accredited family child care homes - no source identified). MO (# of accredited child care facilities). NH (% of child care centers accredited by NAEYC; % of Family child care homes accredited by NFCCA; Total count of NH programs provided by Child Development Bureau of Child Care Licensing). NJ (# of state-licensed child care centers). RI (% of child care centers serving young children that have NAEYC and NAFCC accreditation). WI (% of accredited child care centers - Wisconsin Child Care Research Partnership, Issue Brief No.1, July 2001)

- Child Care Subsidies (GR)

- Child Care-Quantity (GR)
  - State Depts. of Human Services, Licensing Bureaus for selected states and years. AR (Child Care Licenses: By number By capacity) CA (Preschool participation: The percentage of 3-5 year olds enrolled in preschool by income - CPS’s ferret system provides state level preschool participation rates yearly. Census 2000 and CHIS provide preschool participation data for the state. By state, income and some ethnic data). CT Supply of regulated child care: # of slots per 100 children - Child Care Info-line). KS (Child care capacity - no identified source). KY (# of child care center placements for children 0-3; # of child care placements for children 3-5; # of family child care placements - no identified source). ME (Availability of early childhood
education programs; # of slots available in licensed childcare). NJ (# of registered family day care providers). VT (Availability of child care - no identified source).

- **Child Care Quality (GR)**
  - State Dept. of Human Services for selected states and years. AR (Child care licenses meeting quality standards). CT (# of quality early care and education slots - Child Care Info-line). KY (# of programs receiving a STAR rating; # of children served in a STAR rated program). OH (Child care programs that have achieved a quality rating - no identified source).

- **Early Intervention (GR)**
  - RI (% of all children ages birth to 3 enrolled in the Early Intervention program - RI Dept. of Health). VA (Birth to three year olds in community early intervention programs; # of children enrolled birth to three; % of 1 and 2 year olds enrolled - VA Dept. of Mental Health, Mental Retardation and Substance Abuse Services).

- **Special Education Enrollment (GR)**
  - State Depts. of Education for selected states and years. ME (Young children in special education Part C: 0-2 years-Section 619: 3-5 years; # of children entering kindergarten exiting special education to regular education). MA (% of children on special education IEP’s between ages 3-5, and in elementary school). VA (Preschool Special Education: Number and rates per 1,000 of birth to six year olds in public school special education programs).

- **Public Preschool. State Depts. of Education for selected states and years (GR)**
  - ME (Sub-indicator: # of schools with public 4-year-old programs and students served ME as a whole and by # of students and # of schools). NJ (Preschool enrollment). WI (Collaborative 4-year-old kindergarten: % of school districts offering collaborative 4 year old kindergarten).

- **Full Day Kindergarten/Public Kindergarten (GR)**
  - State Depts. of Education for selected states and years. ME (% of all public kindergarten schools offering all-day kindergarten). MA (Full-day kindergarten: % of children enrolled in full-day kindergarten). OH (% of school districts providing full-day kindergarten). RI (% of public school kindergarten children enrolled in a full-day kindergarten program as of October 2003). NH (# of school districts offering public kindergarten).

- **Family Reading to Young Children (GR)**
  - CO (% of infants and children read to on a regular basis - CO
Dept. of Public Health and Environment State as a whole 2005 tentatively

Health

- Trends of nutrition, health, and behavioral indicators for low-income mothers and children: maternal smoking and drinking during pregnancy, anemia, diabetes, hypertension, maternal weight gain, medical care, and multivitamin consumption (PNSS)

- Nutritional status of children 0-5: birth weight, under- and overweight, anemia, and breastfeeding (PedNSS)

- Two year old who received 4:3:1 series coverage (Immunization 2005)

- Immunizations CDC by National Survey of States. Percentage of children with up-to-date immunizations at age 2. % of kindergarteners with up-to-date immunizations at age 2 for selected states

- Low Birth weight by Selected State Depts. of Public Health. Percentage of infants born weighing less than 5.5 lbs

- Prenatal Care (GR)

- Access to Health Care (GR)
  - CT (Children enrolled in HUSKY A Receiving well-child visits on time - 4-24 mths. and 3-5 yrs. old - % with on-time visits Children’s Health Council, EPSDT On-Time Visit Rates, First-Fourth Quarter 2001).

- Health Insurance (GR)
  - Collected for selected states and years - other states based on survey. AZ (% of low-income children under age 6 without health
insurance- National Center for Children in Poverty). CT (Young children enrolled in Medicaid - HUSKY A - birth, ages 1-2, ages 3-5; # of children enrolled in HUSKY A - CT Department of Social Services, CMS Form 416).

- **Lead Poisoning (GR)**
  - State Depts. of Public Health for selected states and years. OH (% of one and two year olds screened for high blood lead levels). VA (Prevalence of elevated blood lead levels and proportion tested under age 6; # and % of children under 6 with elevated lead levels; # of children under age 6 tested for lead per 1,000 children).

**Child Welfare**

- **Demographics of the children and their perpetrators, types of maltreatment, investigation or assessment dispositions, risk factors, and services provided as a result of the investigation or assessment (NCANDS)**

- **Health factors and practices known to be related to later intellectual and socio-emotional development including birth weight, breastfeeding, and parental educational attainment (NCHS)**

- **Status of child in care (AFCARS)**

- **Poverty (GR)**
  - State and National U.S. Bureau of 2000 Census Population, CA CPS - gathered for selected states and years. AR (Poverty rates by family type and presence of child - Summary File 3 US Census; % of children in poverty, 5 to 17 years of age, by school district% of children in poverty, ages 0-4 - estimates) CA (Child poverty rate: % of children living in poverty; Low income children: % of children who qualify for free or reduced-price lunch). CO (% of children living in poverty) CT (Economic status of children under age 6:# of children above or below CT Self-Sufficiency Standards). MO (% of children under 6 in poverty U.S. Census Bureau). NH (% of children under age 6 living below federal poverty level). RI (Children under age 6 by poverty status: % of children under age 6 who live in families below the federal poverty threshold of $14,824 for a family of three with two children). VA (percent of children under age 6 living in poverty) WI (Poverty for children under age 5 2000 Census By race; Neighborhood Conditions - Severely stressed neighborhoods High poverty neighborhoods - % of children living in stressed and severely stressed neighborhoods - tables available from the Annie E. Casey Foundation).

- **Child Abuse and Neglect (GR)**
• Social Service Divisions for the States - gathered for selected states and years. KS (# per 1,000 of substantiated child victims of abuse and/or neglect, ages birth-17). KY (% of children experiencing child abuse and neglect). MO (% of victims with repeated substantiated child abuse/neglect within 6 months). NH (Rate of substantiated abuse or neglect). OH (% of children ages 0-6 living in families with substantiated occurrences of abuse/neglect). RI (The rate of indicated investigations of child abuse and neglect per 1,000 children under age 6). VA (Duplicated counts of founded cases and assessments # unfounded, # assessed # founded, founded rate per 1,000).

➢ Food Security (GR)
  • KY (% of free and reduced lunch eligible four year old children enrolled in preschool programs).

➢ Babies at Risk (GR)

➢ Homeless Children (GR)
  • RI (# of children under age 6 years of age who received emergency housing services at homeless shelters and domestic violence shelters during the previous calendar year - RI Emergency Shelter Information Project 2003).

➢ Children at Risk (GR)
  • Dept. of Education for selected states and years. VA (At risk 4 year olds: 2003-2004 Projections: Title I and Head Start Enrollees; 2003 Virginia Preschool Initiative Enrollees; % of children with free lunch Title 1 preschool Head Start 4 yr. olds - VA Preschool Initiative 4 yr. olds served in eligible localities). KY (# of children spending 5 or more years in primary, K-3).

➢ Foster Care (GR)
  • State Depts. of Social Services for selected states and years. CT (# of young children birth to age 5 in foster care). VA (number of children under age 6 entering and exiting foster care and rate per 1,000 children).

➢ TANF recipients (GR)
• CT (Young children receiving welfare benefits - Temporary Family Assistance-TFA - # of children birth to age 5 receiving welfare benefits -CT Department of Social Services, Form 8017  October 31, 2003).

- Parent Support Services (GR)
  • KS (% of parents of children ages birth-5 involved in a parenting program - no source identified).

Special Initiatives, Projects, and Reports

National Children’s Study

www.nationalchildrensstudy.gov

In 2001 A National Children Study (N = 100,000 - Health and Environmental Monitoring to 21 years) was proposed to start in 2007-08.

The National Children’s Study Program Office awarded contracts in 2005 to seven Vanguard Centers to begin implementing the Study in select communities across the country. Teams from the Vanguard Centers will be the first to work within their communities to recruit participants, collect and process data, and pilot new research methods for incorporation into the full Study.

The National Children’s Study Program Office awarded one Coordinating Center—Westat (with University of Pennsylvania, Harvard Medical School (Harvard Pilgrim Health Care), Daston Communications, Inc., The Helix Group, The Media Network, Syntaxis, Southwest Research Institute, Claritas, Inc., and Peters Consulting, Inc). The Coordinating Center is responsible for information management, statistical sampling, data collection and analysis, and quality control.

Study Centers

- The National Institute of Child Health and Human Development (NICHD) awarded 22 new Study Centers in September 2007. These centers will manage Study operations in 26 of the 105 previously designated Study locations.

- The Study Centers, including the Vanguard Centers, will work within their communities to recruit participants and collect data. Study Centers are responsible for reporting to the Study’s Program Office and some will manage operations in more than one Study location. The newly-awarded Study Centers will begin activities in 26 locations this year, including preparing for recruitment, hiring and training staff, determining community needs, and setting up community advisory boards.
Study Sites

• Of the 105 sites selected, 79 are metropolitan counties and 26 are in rural, non-metropolitan areas as designated by the U.S. Census Bureau. The 79 metropolitan sites include some of the most populous counties in the United States, as well as smaller urban and suburban areas.

• All Study Centers will enroll women who are either pregnant or likely to have a child during recruitment. The goal will be to attain 250 live births per year in each Study location during the four year enrollment period. For some sites, this number of newborns will represent a greater percentage of the total births in the community and will therefore involve a larger number of area communities than in others. For this reason, some counties have been clustered to represent one Study site.

Description of the Project

The National Children’s Study will examine many aspects of children’s lives, from family genetics; to the constructed world of neighborhoods and schools; to chemical exposures linked to the atmosphere, food or water supplies; to the social and behavioral environment in which the children grow and develop. The ability to examine multiple exposures and link them in cause-effect relationships with multiple outcomes is the defining characteristic of the National Children’s Study, and the focus of the Study Plan.

The National Children's Study will observe 100,000 children from before birth to their twenty-first birthdays. Initially, participants will include three distinct groups: pregnant women and their partners, couples planning pregnancy, and women who are of childbearing age but are not planning a pregnancy.

The National Children's Study will be the first effort to capture exposures prior to and early in pregnancy, and to then track participants for more than 20 years. Other studies have looked at prenatal exposures, but they either started in the first trimester of pregnancy, or stopped tracking at birth.

The Study Plan focuses on several priority health themes: outcomes of pregnancy, child growth and development, injury, asthma, and psychological and emotional health. The Plan outlines the measures of exposures and the schedule of data collection for the first few years of the Study.

In developing the Study Plan, the National Children’s Study relied on the expertise and input from the National Children’s Study Federal Advisory Committee; its working groups of experienced obstetric, pediatric and environmental health researchers representing federal agencies, the private sector, child health and environmental advocacy groups; and others.
Hypotheses

Although the Study is hypothesis-driven, no single hypothesis fulfills all the goals for the Study. To determine environmental impact on the health of children, the Study includes a number of hypotheses and priority health outcomes. Together, they represent an approach to addressing the nation’s most urgent public health concerns. By design, the Study hopes to be able to answer future questions about children’s health that science has yet to ask.

Data Collection

- Families who are enrolled in the Study will participate in a minimum of 15 in-person visits with a local research team beginning from the first trimester of pregnancy or earlier, through 21 years of age. Some of these visits will be in the participants’ homes and some will be in clinical settings, including the infant’s place of delivery. For a sample of participants, data will also be collected from child care and school settings to include places where the child spends at least 30 hours per week.

- In addition to in-person visits, data will be remotely collected via telephone, computer, or mail-in questionnaires every three months through pregnancy, every six months through the first year, and then at slightly longer intervals until the child reaches 21 years of age.

- Samples collected over the course of the study will include biological samples from the mother, father, and child, as well as air, water, soil, and dust from the child’s environment will be collected.

Measures and Outcomes

- The data collection will involve measures of environmental exposures that will be tracked and analyzed in relationship to health outcomes. Biological, chemical, physical, and psychosocial exposures will be collected, measured, and tracked against pregnancy and birth outcomes, stages of child development, and medical events.

- The ability to assess the influence of multiple environmental exposures on one or more outcomes is an important and unique facet of the Study.

Results

- Beginning with birth outcomes, findings will become available within two to three years after the Study is launched. Throughout the Study’s duration, intermittent results will allow for continued insights that may be applied to better the health of America’s children.

- The Study Plan is written as an outline so that it may evolve as the cohort ages and as new scientific developments occur. A more detailed Research
Plan and Study protocol will be developed with the input of investigators from the Vanguard Centers and coordinating center.

Tracking Early Child Development From A Health Perspective

www.commonwealthfund.org/publications/publications_show.htm?doc_id=354865

In February of 2006, Brett Brown and Martha Zaslow of Child Trends and Michael Weitzman from the Center for Child Health Research prepared a report: Studying And Tracking Early Child Development From A Health Perspective: A Review Of Available Data Sources for the Commonwealth Fund. The report, reviews existing national data sources paying particular attention to the capacity of these sources to inform child health policy and practice in their efforts to promote early child development. The body of the report provides an overview of existing areas of strength, identifies gaps, and makes recommendations for future data development. Some 20 national surveys and 6 administrative population data sources are assessed for their collective ability to support research and for their adequacy as sources of descriptive social indicator data.

The report is available on the web:

Recommendations supported by the report. This report seeks to expand the sources of federally collected state- and local-level data covering early child health and development which at present exist only in the form of the National Survey of Children’s Health, and to a lesser extent the survey of Children with Special Health Care Needs, data provided by the states. The report notes as well that at present there are virtually no estimates collected on a regular basis (outside of the decennial census) that allow tracking of elements of the local environment such as characteristics of the neighborhoods and communities where young children live that are known to shape early child well-being. The report also recommends the addition of developmental screening assessments for children under age six to the National Health and Nutrition Examination Survey (NHANES). This will create a unique source of data to support research linking health status to early socio-emotional and intellectual development. Existing longitudinal surveys lack such measures, though they have been fielded in cross-sectional surveys; notably the National Survey of Early Child Health (NSECH) lacks more detailed information on the content of developmental screening and well child visits that support research capable of linking specific early health care practices to better intellectual, socio-emotional, and physical developmental outcomes at older ages. Finally, the report calls for an inclusion of a rich set of age-appropriate intellectual and socio-emotional development measures in the National Children’s Study, an extremely ambitious federally sponsored longitudinal study that intends to follow 100,000 children from birth through age 21 (still in the design phase). The planned study will also contain very detailed information on health and health care receipt.
This report is a compendium of indicators—drawn from the most reliable official statistics—illustrative of both the promises and the difficulties confronting our Nation’s young people. The report presents 38 key indicators on important aspects of children’s lives. These indicators are easily understood by broad audiences, objectively based on substantial research, balanced so that no single area of children’s lives dominates the report, measured regularly so that they can be updated to show trends over time, and representative of large segments of the population rather than one particular group. Many of the measures are based on estimates from survey data.

Website: [www.childstats.gov/americaschildren/](http://www.childstats.gov/americaschildren/)
AMERICAN DATABASES BY STATES
The California Children and Families Act of 1998 established the "First 5" initiative, a large-scale comprehensive approach to addressing the health, sustainability, and school readiness of the state’s children and families. The state and counties worked together to create an evaluation framework early in the initiative. First 5 California is presently under some reorganization which has, to some extent, affected the evaluation. Currently, the only assessment that is used is the MDRDP - an assessment adapted from the California Department of Education’s Desired Results Developmental Profile (DRDP). This profile examines ten indicators of healthy development.

It is used with a sample of children, however, and it is not population-based. The MDRDP was most recently used in Fall ’06 and - if all goes according to schedule - will be used again in Fall ’08. In the past, First 5 California reported population data from the California Department of Health Services and the California Health Interview Survey. At this time there is no population based assessment being planned.

The First 5 initiative encompasses four program categories: state programs funded 100 percent by the state, the school readiness program, which is jointly funded by the state and county commissions, county programs that are funded 100 percent by individual counties, and other programs that are jointly funded. The framework, revised in 2005, focuses on two of these categories: 1) 100 percent county-funded programs and 2) the jointly-funded school readiness initiative. Three levels of data are planned in that revision to be collected. These include: 1) descriptive data; Standard reporting by funded application, answering questions regarding: Who is being served; How many are served and by whom? For what purpose and how much is being spent? Information regarding children served will be reported by age, ethnic background and language spoken in the home. 2) outcome data reported aggregated by county from menu of standard outcomes and indicators.; and 3) data produced through experimental and comparison research and evaluation to: (1) evaluate impact of specific initiatives and program executed within or across counties; (2) evaluate the overall impact and return on investment of First 5 through enhanced community capacity and intensive longitudinal studies.
School readiness entails all of the factors that help to prepare a child to enter school and make the most of his or her education. This view of school readiness is relatively new. It emerged in 1989 when President George H. W. Bush and the nation’s governors convened the first National Education Summit to discuss ways to strengthen the educational performance of America’s students. The first goal to come out of the meeting was that “All children will start school ready to learn.” The concept gained further momentum in 1997 when the National Education Goals Panel (NEGP) created the working definition for school readiness that LA uses today:

- Children’s readiness for school (prepared to fully participate in class)
- Schools’ readiness for children (ready to meet the needs of all children they will serve)
- Family and community supports and services that contribute to children’s readiness for school success (offer a household and community environment that supports learning).

The NEGP definition makes clear that school readiness is a community-wide challenge that goes far beyond the classroom and individual homes.

The Los Angeles County Health Survey
www.lapublichealth.org/ha/hasurveyintro.htm

A population based telephone survey that provides information concerning the health of the Los Angeles County residents. The data are used for assessing health-related needs of the population, for program planning and policy development, and for program evaluation. The relatively large sample size allows users to obtain health indicator data for large demographic subgroups and across geographic regions of the County, including Service Planning Areas and Health Districts.

The Los Angeles Family and Neighborhood Survey (L.A.FANS)
www.lasurvey.rand.org

LA FANS is a new longitudinal study of families in Los Angeles County, California, and of the neighborhoods in which they live.
**INDICATORS INCLUDED IN DATABASES**

**Education and Child Care**

- Self concept (DRDP)
- Social and interpersonal skills (DRDP)
- Self regulation (DRDP)
- Language (DRDP)
- Motivation in learning (DRDP)
- Cognitive competence (DRDP)
- Math skills (DRDP)
- Literacy skills (DRDP)
- Motor skill development (DRDP)
- Families have access to quality child care (DRDP)

- Number of children ages 0 to 5 whose parents report that it is “very” or “somewhat” difficult to find the child care they need on a regular basis. Estimated from the Los Angeles County Health Survey.

- Number of licensed child care spaces for children ages 0 to 5. Estimated from the Los Angeles County Office of Child Care data.

- Communities encourage educational attainment for families (DRDP)
  - Number of infants born annually to women, ages 21 or older, who have at least 12 years of education. Data from the Los Angeles County Department of Health Services.
  - Number of infants born annually to men, ages 21 or older, who have at least 12 years of education. Data from the Los Angeles County Department of Health Services.

- Schools and child care programs promote an environment that is conducive to learning (DRDP)
  - Data resources to track LAs progress to this goal have not yet been identified.

- Schools, families, and caregivers work together to ensure a positive transition to K-6 education (DRDP)
  - Data resources to track LAs progress to this goal have not yet been identified. Potential measures could be collected through school administrative data or through parent surveys. Administrative data on
numbers and percentages of schools with transition programs and/or articulated curricula with feeder preschools may be feasible to compile and monitor, but these measures would not capture the quality and/or “ease” of the transition unless these transition programs could at least be classified into low, medium and high intensity programs. Surveying parents on their perceptions of the quality of school transition programs might provide more accurate data on the ease of the transition, but collecting these data on a wide scale may not be feasible based on cost or other considerations.

- Communities support families and children with special needs (DRDP)
  - Number of children, ages 3 and 4, who are identified with serious, but often missed, disabilities and are enrolled in special education programs. Children enrolled in preschool special education programs, according to the California Department of Education.

Health

- Children are born at healthy birth weights (DRDP)
  - Number of newborns with low and very low birth weights. Tracked by the Los Angeles County Department of Health Services.

- Children receive preventive health care (DRDP)
  - Number of children ages 0 to 5 whose parents report that they have a regular source of health care. Estimated from the Los Angeles County Health Survey* for children age 0 to 5 years.
  - Number of children ages 0 to 5 who have health insurance. Estimated from the Los Angeles County Health Survey for children age 0 to 5 years.
  - Hospitalizations of children age 5 and younger resulting from asthma. Estimated from the Los Angeles County Health Survey for children age 0 to 5 years.

Child Welfare

Personal safety and health routines (DRDP)

Children are free from abuse and neglect and thrive in permanent homes.
• Child abuse and neglect reports to DCFS that result in Emergency Response services for children ages 0 to 5. Tracked as the number of for children ages 0 to 5 referred to the Los Angeles Department of Children and Family Services who subsequently received. Emergency Response services based upon reports of abuse and neglect.

➢ Families ensure that kids are safe from unintentional injuries (DRDP)

• Data resources to track LAs progress to this goal have not yet been identified. The National Health Interview Survey (NHIS) child supplement has asked parents to report on accidental injuries and poisonings in the past year. Administrative data is typically collected on injuries requiring the use of emergency rooms or inpatient visits. However, these may be limited only to severe injuries and may reflect differences in access to health care. LA may is considering adding the NHIS question to the Los Angeles County Health Survey. Additionally the Office of Statewide Health Planning and Development (OSHPD) collects data on accident/injury related hospital discharges for children 0 to 5.

Communities offer safe places for children to live and play (DRDP)

• Number of children ages 1 to 5 whose parents say they can easily get to a park, playground or other safe place to play. Estimated from the Los Angeles County Health Survey.

Families have adequate food (DRDP)

• Number of households, with dependents under age 18 and below 300 percent of poverty that are food insecure. Estimated from the Los Angeles County Health Survey.

Families have adequate financial resources (DRDP)

• Number of children ages 0 to 5 living in families with incomes below 200 percent of the Federal Poverty Level. Reported from census analysis by the Los Angeles County Urban Research.

Communities offer affordable housing for families (DRDP)

• Data resources to track LAs progress to this goal have not yet been identified. Suggested are: Tracking the percent of families with children age 0 to 5 that own their home - the National Household Education Survey parent interview collects this information. The U.S. Census also collects data on home ownership.
Another possible indicator, suitable for inclusion in a household survey such as the Los Angeles County Health Survey, is the percentage of parents of children age 0 to 5 that have moved more than once in the past year.

- Families have supportive networks and are able to find information and assistance (DRDP)
  - Number of children ages 0 to 5 whose parents say it is “very” or “somewhat” easy to find someone to talk to when they need advice about raising their child. Estimated from the Los Angeles County Health Survey.

- Families and caregivers interact with children in ways that promote cognitive, linguistic, social-emotional and physical development (DRDP)
  - Number of children ages 0 to 5 who are read to daily by a parent or family member. Estimated from the Los Angeles County Health Survey.
Washington State

Communities Count: www.communitiescount.org

Description of Databases

Communities Count (CC)
Kings County WA has a stated commitment to developing a set of social and health indicators for the county in order to provide an accepted index for monitoring the health and well being of King County communities. This data is to be used to inform funding decisions and engage citizens in following the communities’ progress. To that end, the county has partnered with local government agencies and foundations to create Communities Count. Three principles have guided the project: 1. Prevention and a long-term view of change are emphasized. 2. A data-based approach informs our understanding of what creates and sustains healthy communities and families. 3. Effective efforts involve citizens and experts, different disciplines, different parts of government, private and public sectors.

The process has been extensive, involving over 1,500 King County residents who participated through a random digit dial telephone survey, a series of focus groups, and seven public forums held across the county. Their opinions were recorded and are expressed as “valued conditions.” At the same time, technical advisors were discussing the scientific side of choosing a strong list of social and health indicators. They considered the valued conditions expressed by residents and were concerned with the scientific quality of the information available issues of validity, reliability, consistency of measurement, whether data are available for the county only or for smaller areas, such as school districts, cities, regions, or for different age groups, ethnic groups, income levels and genders. The indicators selected were the most meaningful to residents and those considered most important to the overall health and wellbeing of people and communities.

Since 2000, when the first Communities Count report was released, two more reports have been issued with Communities Count 2005 as the third and most current report on these indicators, reflects conditions in King County which have changed, as well as those which have remained fairly constant over the past five years. Part of the objective of the Communities Count project was to monitor information on early child development. Three of the 5 early child development indicators relate to community influence on early child development.

INDICATORS INCLUDED IN DATABASES
Education and Child Care

- Family-Friendly Employment Benefits such as paid vacations, paid holidays and sick leave (CC)
  - The information was gathered from a variety of surveys of private and non-profit organizations and from the Washington State Population Survey.

Affordable, Quality Child Care (CC)

- Measures as: Percent of children (birth to age 5) who are in regularly scheduled child care; Percent of children in child care by type of child care service; Among parents whose child is not in first choice child care, reason for compromise; Among parents who desire change in child’s care, type of change desired. Data was gathered by King County Community Health Survey. Cost, compensation and attrition information comes from “Licensed Child Care in Washington State: Washington State Department of Social and Health Services, and from Child Care Resources.

School Readiness

- Three school districts in King County have implemented the Early Development Instrument (EDI) survey. Five areas of school readiness are measured: 1) physical health and wellbeing, 2) emotional maturity, 3) social competence, 4) language and cognitive skill, and 5) communication and general knowledge.
  - Bellevue and Shoreline School Districts carried out the survey in 2004 and Highline School District in 2005. Because only 3 school districts have implemented the school readiness survey so far, it is not yet possible to create a King County EDI Normative Score for the sake of comparing one group of children’s school readiness with others. Instead comparisons are with the international Normative Score using results available from Canada, Australia and the 3 King County school districts. This is used for purposes of comparing local school district readiness with all children who have been evaluated by the EDI. Teacher participation was voluntary and resulted in participation rates between 84% and 89%. The definition of neighborhoods within school district boundaries was based on input from city and school district administrators, existing boundaries of incorporated areas, census block group boundaries, social and economic characteristics of the population within census block groups, and a minimum number of kindergarten children included in the survey who resided in each neighborhood.
• Academic Achievement. State standards, Essential Academic Learning Requirements for student learning, are developed in reading, writing, communication, mathematics, science, social science, and the arts.

  • These standards are used to assess all 4th, 7th and 10th grade children in public school. Starting in the year 2008, students must meet standards on the 10th-grade Washington Assessment of Student Learning (WASL) in reading, writing and math, in order to graduate from high school. Cities

• Parent/Guardian Involvement in Child’s Learning. Measured as % of households with children age 2-5 where children were read or told stories every day by a family member (CC)
Illinois

Chapin Hall:

Special Projects, Reports and Initiatives

Chicago Children and Youth 1990-2010

Changing Population Trends and Their Implications for Services (2007). Robert M. George, John Dilts, Duck-Hye Yang, Miriam Wasserman, Anne Clary. This report draws on demographic data to examine and project trends in the size and composition of the child population in all seventy-seven Chicago communities up to the year 2010. The report highlights the changing age mix of Chicago children and provides some context in which to consider these demographic trends. It describes population changes across Chicago communities and identifies the communities in which greater and lesser numbers of children are living in poverty. The report also explores the implications of the changes, trends, and projections for social services, schools, and early childhood education and after-school programs. Finally, it offers some conclusions to help government and program planners build capacity to respond to the one constant—ongoing change. The analyses have yielded four overarching findings:

- Population density within the city has changed since 1990 as areas near the Loop and the lakefront lost families with children and neighborhoods on the northwest, southwest, and southeast sides have gained them.

- The change in the size of the Hispanic population in Chicago has been the primary driver of demographic change in many communities as Hispanic (and, to a lesser degree, Asian and other) immigrants have moved into the city and Hispanics have exhibited greater fertility than other groups.

- Although communities that have historically been low-income remain so, as communities on the northwest and southwest sides have grown, an increase in the number of children living in poverty in those communities has occurred.

- Communities vary greatly in the number of available services for the target populations in them.
CANADIAN DATABASES
National Databases

Birth Database and Vital Statistics:
www.statcan.ca/english/freepub/84F0210XIE/2002000/technote2.htm
Health: www.phac-aspc.gc.ca/index-eng.php

Description of Databases

Birth Database & Vital Statistics (BDVS)
This is an administrative survey that collects demographic information annually from all provincial and territorial vital statistics registries on all live births in Canada. Some data are also collected on live births to Canadian residents in selected American states.

The data are used to calculate basic indicators (such as counts and rates) on births of residents of Canada. Information from this database is also used in the calculation of statistics, such as age-specific fertility rates.

For Canada as a whole, it was impossible to compile a satisfactory series of vital statistics prior to 1921. Eight provinces initially joined the cooperative Canadian vital statistics system, leading to the publication of the first annual report for Canada in 1921; that report included Prince Edward Island, Nova Scotia, New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia. Quebec began to participate in 1926 and Newfoundland in 1949 (after joining Confederation) and their data were included in the tabulations from those years onward. Basic data from the Yukon and Northwest Territories were published as appendices to the national tables from 1924 to 1955; their data were first included in the regular tabulations in 1956. Nunavut came into being officially as a Territory of Canada on April 1, 1999. The name Northwest Territories applies to a Territory with different geographic boundaries before and after April 1, 1999.

Prior to 1944 all vital events were classified by place of occurrence. Since 1944, births, stillbirths, and deaths have been classified by area of reported residence, with births and stillbirths according to the residence of the mother.

Survey population: The conceptual universe of the Birth database is births to Canadian resident women anywhere in the world. The target population of the Birth database is births to Canadian resident women in Canada and to Canadian resident women in American states. The actual (survey) population of the Birth database is births to Canadian resident women and non-resident women in Canada, and births to Canadian resident women in some American states.

Sampling: This survey is a census with a cross-sectional design.
Collection: Responding to this survey is mandatory. Data are extracted from administrative files.

Provincial and territorial Vital Statistics Acts (or equivalent legislation) render compulsory the registration of all live births, stillbirths, deaths and marriages within their jurisdictions. These Acts follow, as closely as possible, a Model Vital Statistics Act that was developed to promote uniformity of legislation and reporting practices among the provinces and territories.

The Canadian Vital Statistics system operates under an agreement between the Government of Canada and governments of the provinces and territories. The Vital Statistics Council for Canada, an advisory committee set up by an Order-in-Council, oversees policy and operational matters. All provincial and territorial jurisdictions and Statistics Canada are represented on the Vital Statistics Council. Under the agreement, all registrars collect a specified set of data elements, although any of them may decide to collect additional information.

The main form for the registration of a live birth is completed by the parents, who are responsible for filing it with the local registrar. Most provinces also require physicians (or other birth attendants) to report all births.

All provinces and territories supply microfilm copies or optical images of registration forms to Statistics Canada. In addition, Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Ontario and the Western provinces supply machine-readable abstracts of registrations, which contain the required standard information. For the territories, the required standard information on microfilm is converted to machine-readable format at Statistics Canada. Subsequent changes to registrations due to errors or omissions are transmitted to Statistics Canada as the information becomes available. However, changes received after a cut-off date are not reflected in published tabulations.

The central Vital Statistics Registry in each province and territory provides data from birth registrations to Statistics Canada. The following statistical data items are reported for each birth by all provinces and territories for inclusion in the Canadian Vital Statistics system:

The Early Development Instrument (EDI)
School Readiness to Learn (SRL) PROJECT
Offord Centre for Child Studies

Websites: www.offordcentre.com/index.html
www.offordcentre.com/readiness/results.html
www.offordcentre.com/readiness/pubs/publications.html

The Early Development Instrument (EDI): A population-based measure for Communities” (EDI) reflects the fact that it measures the outcome of the early years. At the same time, however, it provides information on children’s readiness
to learn at school. This refers to a child’s ability to meet the task demands of school, such as: playing and working with other children, listening to the teacher, remembering and following rules, and being comfortable exploring and asking questions. The EDI is a short, teacher-completed instrument which measures Children’s readiness in five domains: physical health and well-being; social knowledge and competence; emotional health/maturity; language and cognitive development; and general knowledge and communication skills.

The instrument has been designed to provide information for groups of children in order to:

1. Report on populations of children in different communities,
2. Assess the strengths and deficits in students, and
3. Predict how children will do in elementary school.

The Offord Centre for Child Studies, at McMaster University, is a national repository of the EDI data. The majority of the Early Development Instrument data is also processed at the Centre. Once data has been collected and analysed, each school site receives a report consisting of four separate documents:

1. Demographic frequency tables and simple comparisons for all students in the sites (e.g., girls vs. boys);
2. Descriptive report which puts the site results in perspective;
3. Behavioural profiles of children with the highest and lowest scores for each scale;
4. School-level reports, which are one-page summaries of each school EDI data, including frequencies of all demographic variables, means, standard deviations, and percentages of students scoring in various percentile ranges for each scale.

Offord Centre also produces cohort and provincial level reports as well as a set of 6 reports for each community/city who implements the EDI. An example of these reports is available at: [www.offordcentre.com/readiness/reporting.html](http://www.offordcentre.com/readiness/reporting.html). These reports are sent to the community coordinator along with the datasets and are then left in the hands of the coordinator and school boards to disseminate further.

As of July 3, 2007, the total number of children in the EDI database was over 500,000. British Columbia, Manitoba, and Ontario have implemented the EDI for all kindergarten children over the past several years. The progress to date in terms of the number of communities and students per year where the EDI has been administered can be found at: [www.offordcentre.com/readiness/progress.html](http://www.offordcentre.com/readiness/progress.html).

The EDI database is not publicly accessible.
Regulated Child Care Data Collected By Provinces/Territories (RCC)

This data covers child care centres, regulated family child care and nursery school/preschools in jurisdictions where they are regulated. Data exists on the following aspects:

Capacity: Number of spaces in centres by age groupings recorded in all jurisdictions/provinces/territories provide broken down into age categories. Age groupings of children are defined differently depending on the province or territory. For example, infants are from 0-23 months in Newfoundland, less than 12 months in P.E.I., and 0-17 months in Nova Scotia.

Enrolment: Provinces collect enrolment figures by age range of children. In most cases, these age ranges are typically the same as those used to collect information about “capacity.”

Children receiving fee subsidies: Enrolment figures provided by most provinces/territories but data concerning the actual ages (i.e., year of age or birth) of children in child care are not typically available and type of placement is not necessarily available.

Children in regulated family day care: The actual ages of children are not available (with the exception of Alberta) but most provinces/territories collect data about the age ranges of children in order to ensure compliance with legislation. All provinces/territories have information on the number of subsidized children enrolled in family child care.

Hours - Most provinces/territories have information about the hours of service provided by the centre-based programs they license but the detail collected varies from one jurisdiction to another. Most jurisdictions (with Ontario and B.C. as exceptions) have information about the hours of service provided by the regulated family child care homes.

Wages - Most provinces/territories do not collect data on wages and benefits of workers in centre-based programs. Almost no provinces have information about provider compensation in regulated family child care.

Provider qualifications - About half the jurisdictions have information about family child care providers’ qualifications.
Cost - Most have information about the price of a subsidized child care space provided in regulated family child care homes.
On-reserve child care - Most provinces have some information about on-reserve child care programs (the number of programs) although not all are regulated. Some have information about Aboriginal Head Start programs.

The Public Health Agency of Canada (PHAC)
www.phac-aspc.gc.ca/index-eng.php

PHAC collects data on the following events for children aged <1 year; 1-4 years, 5-9 years and older age groups through various systems described below:


2. Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP)
This is a computerized information system that collects and analyzes data on injuries to people (mainly children) who are seen at the emergency rooms of the 10 pediatric hospitals and of 4 general hospitals in Canada. CHIRPP is a unique, richly detailed database of “pre-event” injury information obtained by asking:
What was the injured person doing when the injury happened?
What went wrong?
Where did the injury occur?

Hospitals participating in CHIRPP
- The Janeway Children's Health and Rehabilitation Centre in St. John's, Newfoundland
- The IWK Health Centre in Halifax, Nova Scotia
- Hôpital de l'Enfant-Jésus in Quebec, Quebec.
- CHU Ste-Justine in Montreal, Quebec
- The Montreal Children's Hospital, of the McGill University Health Centre in Montreal, Quebec
- Children's Hospital of Eastern Ontario in Ottawa, Ontario
- Hotel Dieu Hospital in Kingston, Ontario
- Kingston General Hospital in Kingston, Ontario
- The Hospital for Sick Children in Toronto, Ontario
- Children's Hospital of Western Ontario in London, Ontario
- Winnipeg Children's Hospital in Winnipeg, Manitoba
- Alberta Children's Hospital in Calgary, Alberta
- BC Children's Hospital in Vancouver, British Columbia
- Stanton Territorial Hospital in Yellowknife, Northwest Territories

CHIRPP reports are based on information from the database of the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP). It is important to note that the injuries described do not represent all injuries in Canada, but only
those seen at the emergency departments of the 14 hospitals in the CHIRPP network. Since the bulk of CHIRPP data comes from hospitals in cities, and most are pediatric hospitals, injuries suffered by the following people are under-represented in the CHIRPP database: older teenagers and adults, who are seen at general hospitals; First Nation and Inuit people and other people who live in rural and remote areas. Fatal injuries are also under-represented in the CHIRPP database because the emergency department data do not capture information about people who died before they could be taken to hospital or those who died after being admitted to hospital.

3. Vital Statistics (VS)
Every year, the provinces and territories send their birth, stillbirth and death registration data to Statistics Canada. Statistics Canada compiles these data into national databases of births, stillbirths and deaths, called the Canadian Vital Statistics System. The vital statistics registration system covers all births and deaths occurring in Canada. Births and deaths of Canadian residents occurring in the United States are also included, being reported under a reciprocal agreement. However, births and deaths of Canadian residents occurring in countries other than Canada and the United States are not reported.

1. Hospitalization Data (CIHI - DAD)
Canadian Institute for Health Information (CIHI) The Canadian Institute for Health Information (CIHI) maintains the Discharge Abstract Database (DAD), which captures hospital separation — transfer, discharge or death — from the majority of Canada’s acute care hospitals. The DAD is an electronic database that includes information on inpatient acute, chronic and rehabilitation care and day surgery, accounting for about 85% of all acute care hospital inpatient discharges in Canada. The information is obtained directly from the participating hospitals. The DAD contains considerable data on each hospitalization, including demographic and residence information, length of stay, most responsible diagnosis, secondary and co-morbid diagnoses and procedures performed during the hospitalization. Diagnoses are coded in the DAD according to the International Classification of Diseases (ICD) and procedures are coded according to the Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP). The DAD also categorizes hospitalizations by case mix group (CMG, a classification according to diagnosis and intensity of care required).

5. Hospital Morbidity Database
CIHI also maintains the Hospital Morbidity Database, which covers 100% of acute care hospital separations - transfer, discharge or deaths - in Canada. This database contains fewer data elements than the DAD. In addition to demographic and administrative information, the database contains the primary, or most responsible, diagnosis and some procedure codes.

6. Canadian Congenital Anomalies Surveillance System (CCASS)
CCASS data are largely culled from the Discharge Abstract Database (DAD) of the Canadian Institute for Health Information. Additional data sources are also
used, particularly to provide better information for provinces inadequately covered by the DAD. The Manitoba hospitalization database is used to obtain complete data for Manitoba, and Québec data are obtained from Système de maintenance et d'exploitation des données pour l'étude de la clientèle hospitalière (Med-Écho); these two systems are similar to the DAD. Alberta uses its own reporting system, the Alberta Congenital Anomalies Surveillance System (ACASS).

Perinatal Health Relevant Content: The data items that are used in compiling the CCASS statistics are all live births, stillbirths and infants born with a diagnosis of congenital anomaly corresponding to one or more codes that fall within 740-759 of the International Classification of Diseases, Ninth Revision (ICD-9). Variables such as birth date, sex, vital status, other demographic details and the absence/presence of congenital anomaly are recorded in CCASS. To identify cases diagnosed after newborn discharge, CCASS follows infants for one year (through record linkage within the hospitalization databases). Since the personal identifiers are removed from the records, CCASS identifies and combines duplicate readmission records (diagnosed congenital anomalies occurring in the same infant) using scrambled health insurance number, sex, date of birth, province, postal code, geographic code and ICD-9 codes.

6. Canadian Perinatal Surveillance System (CPSS)

www.phac-aspc.gc.ca/rhs-ssg/overview-apercu_e.html
The Canadian Perinatal Surveillance System (CPSS) is part of the Public Health Agency of Canada’s (PHAC) initiative to strengthen national health surveillance capacity. The CPSS is an ongoing national health surveillance program delivered through the Maternal and Infant Health Section. Its mission is to contribute to improved health for pregnant women, mothers and infants in Canada.

The CPSS is based on the concept of health surveillance as a systematic, ongoing process that provides timely, relevant information about trends and patterns in the health status of a population and the factors that influence health status. The components of surveillance are data collection, expert analysis and interpretation, and response (communication of information for action).

CPSS Goals:
The CPSS has established short, medium and long-term goals. In the short and medium term, the CPSS will:

- Continue to analyze and report on existing national perinatal health data such as vital statistics, hospitalization databases and national surveys (e.g. National Longitudinal Survey of Children and Youth) - using a set of national perinatal health indicators.

- Work collaboratively with partners to standardize definitions of perinatal health variables across the country, and promote the addition of key variables to existing databases.
• Strengthen and expand surveillance in priority areas, e.g: (1) congenital anomalies and (2) women’s knowledge, perspectives, practices and experiences in pregnancy, birth and parenthood.

The long term goal of the CPSS is to establish a comprehensive national perinatal database through electronic transfer of data from vital event registration, hospital services and community-based services.

The CPSS identified 52 perinatal health indicators, consisting of measures of maternal, fetal and infant health determinants and outcomes. The complete list of these indicators can be found in the document “Perinatal Health Indicators for Canada”.

The CPSS is currently reporting on 27 perinatal health indicators. They are listed below and are separated in two major categories with four subcategories.

A: Determinants of Maternal, Fetal and Infant Health

1. Behaviours and Practices

   - Rate of Maternal Smoking during Pregnancy
   - Rate of Maternal Alcohol Consumption during Pregnancy
   - Rate of Breastfeeding
   - Rate of Low Maternal Education
   - Rate of Live Births to Teenage Mothers
   - Rate of Live Births to Older Mothers

2. Health Services

   - Rate of Labour Induction
   - Rate of Cesarean Delivery
   - Rate of Operative Vaginal Delivery
   - Rate of Trauma to the Perineum
   - Rate of Early Maternal Discharge from Hospital after Childbirth
   - Rate of Early Neonatal Discharge from Hospital after Birth

B: Maternal, Fetal and Infant Health Outcomes

3. Maternal Health Outcomes

   - Maternal Mortality Ratio
   - Severe Maternal Morbidity Ratio
   - Induced Abortion Ratio
   - Rate of Ectopic Pregnancy
   - Rate of Maternal Readmission after Discharge following Childbirth

4. Fetal and Infant Health Outcomes
Preterm Birth Rate
Postterm Birth Rate
Small-for-Gestational-Age Rate
Large-for-Gestational-Age Rate
Fetal Mortality Rate
Infant Mortality Rate and Causes of Death
Severe Neonatal Morbidity Rate
Multiple Birth Rate
Prevalence of Congenital Anomalies

Rate of Neonatal Hospital Readmission after Discharge following Birth

CPSS Cycle
The aim of the CPSS is to collect and analyze data on all recognized pregnancies, regardless of their outcome - abortion, ectopic pregnancy, stillbirth or live birth - and on the health of the baby during the first year of life. The principal data sources of the CPSS are the Statistics Canada Vital Statistics System, the Canadian Institute for Health Information, Discharge Abstract Database (CIHI DAD), the ’Système de maintenance et d’exploitation des données pour l’étude de la clientèle hospitalière) MED-ECHO, the Population and Health Research Unit, Dalhousie University in Nova Scotia, the Manitoba Hospital Abstract System and the National Longitudinal Survey of Children and Youth (NLSCY). These data are analyzed collaboratively with perinatal health surveillance partners.

7. Public Health Information System (iPHIS)
The Public Health Information System (iPHIS) is part of Public Health Agency of Canada. It is an automated, integrated, client health record and reporting system that supports public health provider interventions, tracking, follow-up, case management, and reporting. iPHIS includes immunization tracking, communicable disease case management, and surveillance components and is designed to be used centrally, providing secure access to one client record by multiple public health providers and programs and allowing communicable disease surveillance and immunization information to be shared.

The iPHIS application has been made available without any licensing fees by Public Health Agency of Canada to all public health jurisdictions across Canada. As a public health case management tool, iPHIS is a key component of Public Health Agency of Canada Canadian Integrated Public Health Surveillance (CIPHS) project and is part of the project’s objective to deliver solutions for the management of detailed and accurate information about health events.

iPHIS adheres to national data standards to enable data sharing and can be used as part of an emerging national network of health surveillance. iPHIS has the option of providing a secure access to a single client record by many public health providers and programs and information to be shared as defined by the user.
While improved information sharing is a goal for all areas of health surveillance, the initial F/P/T priorities are focused on using technology to improve health surveillance in communicable diseases, immunization, and vaccine associated adverse events. CIPHS works closely with many program initiatives areas such as the National Immunization Strategy and the FPT Communicable Disease Surveillance Subgroup.

In addition, the CIPHS initiative is an important step in developing the public health components of the Electronic Health Record (EHR) now under development by Canada’s federal, provincial and territorial health authorities. Through its work, CIPHS will contribute to the development of:

- Protocols for activities, such as access to provincial registries, client files and labs;
- Tools to support the EHR architecture (e.g. messaging);
- Best practices on the governance and management of shared F/P/T public health applications.

## Indicators Included in Databases

### Demographics and Vital Statistics

- Date and place of birth (BDVS)
- Child’s sex, birth weight and gestational age (BDVS)
- Parents’ age, marital status and birthplace (BDVS)
- Mother’s place of residence (BDVS)
- Type of birth (single or multiple) (BDVS)
- Parity (BDVS)
- Births and deaths (VS)
- Preterm Birth Rate (CPSS)
- Postterm Birth Rate (CPSS)
- Fetal Mortality Rate (CPSS)
- Infant Mortality Rate and Causes of Death (CPSS)
- Severe Neonatal Morbidity Rate (CPSS)

### Child Care and Education

- Fetal Mortality Rate (CPSS)
- Capacity (RCC)
- Enrolment (RCC)
- Children receiving fee subsidies (RCC)
- Children in regulated family day care (RCC)
➢ Hours of operation (RCC)
➢ Wages (RCC)
➢ Provider qualifications (RCC)
➢ Cost (RCC)
➢ On-reserve child care and Aboriginal Head Start (RCC)

**Health**

➢ Injuries hospitalizations and deaths: Reports class of injury (eg. suicide, MVTC) (PHAC-CS)

➢ Child injuries and pre-event information (CHIRPP)
  • Inpatient acute, chronic and rehabilitation care and day surgery (CIHI-DAD) (demographic and residence information, length of stay, most responsible diagnosis, secondary and co-morbid diagnoses and procedures performed during the hospitalization.)

➢ Hospital morbidity (CIHI)
➢ Diagnosis of congenital anomaly from birth to one year of age (CCASS)
➢ Rate of Maternal Smoking during Pregnancy (CPSS)
➢ Rate of Maternal Alcohol Consumption during Pregnancy (CPSS)
➢ Rate of Breastfeeding (CPSS)
➢ Rate of Low Maternal Education (CPSS)
➢ Rate of Live Births to Teenage Mothers (CPSS)
➢ Rate of Live Births to Older Mothers (CPSS)
➢ Rate of Labour Induction (CPSS)
➢ Rate of Cesarean Delivery (CPSS)
➢ Rate of Operative Vaginal Delivery (CPSS)
➢ Rate of Trauma to the Perineum (CPSS)
➢ Rate of Early Maternal Discharge from Hospital after Childbirth (CPSS)
➢ Rate of Early Neonatal Discharge from Hospital after Birth (CPSS)
➢ Maternal Mortality Ratio (CPSS)
➢ Severe Maternal Morbidity Ratio (CPSS)
➢ Induced Abortion Ratio (CPSS)
➢ Rate of Ectopic Pregnancy (CPSS)
➢ Rate of Maternal Readmission after Discharge following Childbirth (CPSS)
➢ Small-for-Gestational-Age Rate (CPSS)
➢ Large-for-Gestational-Age Rate (CPSS)
➢ Multiple Birth Rate (CPSS)
➢ Prevalence of Congenital Anomalies (CPSS)
➢ Rate of Neonatal Hospital Readmission after Discharge following Birth (CPSS)
➢ Immunization tracking, communicable disease case management (iPHIS)
Child Welfare

- Young victims of crimes/complainants (includes children from birth onwards)
  - Reported by Statistics Canada, Uniform Crime Reports. Aggregated police service reports; includes crimes charged, suspected, and chargeable.

Special Projects, Reports or Initiatives

Canadian child welfare services

The CIS-2003 tracked 14,200 child maltreatment investigations conducted in a representative sample of 63 Child Welfare Service Areas across Canada in the fall of 2003. In all jurisdictions excluding Quebec, child welfare workers completed a three-page standardized data collection form; in Quebec, information was extracted directly from an administrative information system. Weighted national annual estimates were derived based on these investigations. The following considerations should be noted in interpreting CIS statistics:

- The study is limited to reports investigated by child welfare services and does not include reports that were screened out, cases that were investigated only by the police, or cases that were never reported;
- The study is based on the assessments provided by the investigating child welfare workers, which were not independently verified;
- Because the study is not designed to conduct regional comparisons, variations in rates of investigated cases of maltreatment across Canada cannot be examined;
- Most of the tables in the CIS-2003 Major Findings Report do not include Quebec;
- All estimates are weighted annual estimates for 2003, presented either as a count of child maltreatment investigations (e.g., 14,200 child maltreatment investigations) or as the annual incidence rate (e.g., 38.33 per 1,000 children); and
- There are many reasons to explain the overall increase in rates of investigated and substantiated maltreatment between 1998 and 2003, including changes in reporting.
Childcare Resource and Research Unit (CRRU)

www.childcarecanada.org

The Childcare Resource and Research Unit (CRRU) at the University of Toronto is a policy and research facility that maintains a comprehensive resource collection of materials on a variety of topics focused on early learning and child care.


“Early Childhood Education and Care in Canada 2004” provides cross-Canada data and information on regulated child care, kindergarten, maternity and parental leave together with relevant demographic information. Provincial/territorial profiles on regulated child care include: varieties of ECEC services; number of spaces; standards and regulations; service monitoring and enforcement; funding; history; and recent developments. The Big Picture section presents cross-Canada table compilations of material topic-by-topic. The Long View section presents cross-Canada tables of information on child care since the early 1990s. The report includes an examination of the state of ECEC in Canada, federal ECEC programs, Aboriginal ECEC, and further readings. There are two earlier editions (1998 & 2001).

National Longitudinal Study of Children and Youth (NLSCY)

www12.statcan.ca/english/census06/reference/consultation/92-135/nationalchildren.cfm

Statistics Canada and Applied Research Branch, Human Resources Development Canada (Continuing survey; every two years from 1994 with a representative sample)

This longitudinal study includes 22,831 children age 0-11 and their parents. Begun in 1994, the NLSCY allows researchers to track changes in the same children over time. This is the most comprehensive data currently collected on children and the services they use, as well as family characteristics, child health and development, behaviour, relationships, education, and a variety of child outcome measures. While it is based on a large sample, children added as cohorts grow up are not followed longitudinally. Nor is the sample size large enough to examine particular groups of interest, e.g., children in rural communities, single-parent families or immigrants.
Although this survey is useful for examining child and parental outcomes in a general sense, there is insufficient information (i.e., data on quality is not available) about characteristics of ECEC services to draw conclusions about the associations between these. Sample sizes are not large enough to carry out analyses that assign children to different categories of ECEC arrangements (for example, child care centre, etc.). On the other hand, the longitudinal character of the data set allows for an assessment of changes in child care arrangements over time. Statistics Canada conducts a new cycle every 2 years with some changes in data collected and special add-on surveys.

**Understanding the Early Years**


The UEY initiative is an innovative community research pilot launched in 1999 to equip communities with the information and knowledge to understand the development of children in their community and to explore the influence of community factors on the development of young children. Through UEY, information is gathered about children in the community, child development outcomes, families and existing support mechanisms. This information helps communities to develop the most appropriate programs and services for families and their young children.

UEY helps advance the Government of Canada’s agendas for children, communities and lifelong learning. It complements the Federal/Provincial/Territorial September 2000 Early Childhood Development Agreement and the March 2003 Multilateral Framework on Early Learning and Child Care Shared Outcome(s).

At present, the following communities are involved (2005):

**BRITISH COLUMBIA**
- UEY Greater Victoria, Community Social Planning Council of Greater Victoria, Victoria
- UEY Mission, United Way of the Fraser Valley, Abbotsford
- UEY Okanagan Similkameen, School District No. 53 (Okanagan Similkameen), Oliver
- UEY Sunshine Coast, Powell River, Youth and Family Services Society, Powell River
- UEY Campbell River, Campbell River Child Care Society, Campbell River
- UEY North Shore, North Shore Community Resources, North Vancouver

**SASKATCHEWAN**
- UEY Northeast Saskatchewan, Northeast Regional Intersectoral Committee, Melfort
MANITOBA
- UNEY Lorette, Division scolaire franco-manitobaine, Lorette

ONTARIO
- UNEY Niagara Region, Early Childhood Development Centre, St. Catharines
- UNEY Ottawa, Success by 6/6 ans et gagnant, Ottawa
- UNEY Northern Region of Ontario, Wawa Parent-Child Play Centre, Wawa
- UNEY Kawartha Lakes and Haliburton County, Early Years Centre, Lindsay
- UNEY Lower Hamilton, Wesley Urban Ministries, Hamilton
- UNEY Milton, Halton Child and Youth Services, Burlington
- UNEY Northumberland County, Northumberland Child Development Centre, Port Hope

QUEBEC
- UNEY Pointe-de-l’Île, Centre 1, 2, 3, Go! Pointe-de-l’Île, Montréal
- UNEY YALDEI, YALDEI Developmental Centre, Montréal

NEW-BRUNSWICK
- UNEY Greater Saint-John, Family Plus/Life Solutions Inc., Saint John

NOVA SCOTIA
- UNEY Cumberland County, Cumberland Mental Health Services, Amherst
- UNEY Halifax West and Area, Sackville/Bedford Early Intervention Society, Lower Sackville
- UNEY Western Nova Scotia, Nova Scotia Community College, Kingstec Campus, Kentville


An Update of Early Childhood Development Results in Four Canadian Communities July 2005 (Posted to the Internet January 2007)
This report highlights some of the key findings from data collected from four diverse ULEY pilot communities: Prince Albert, Saskatchewan; Winnipeg, Manitoba; Prince Edward Island; and Southwest Newfoundland. The findings address how kindergarten children are doing in each community and family and community factors which influence young children’s development.
Source: Human Resources and Social Development Canada

The February 2, 2004, Speech from the Throne committed the Government to extend ULEY to at least 100 communities. The March 23, 2004, federal budget allocated $68 million over seven years for the expansion of ULEY to 100 communities.

Contact Information:
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Sources of Associated and Supplementary Data

www.childcarecanada.org/pubs/other/data/State_data.pdf

A number of sources provide either fragmentary information about early childhood education and care (ECEC) or related information about families and children (but not about ECEC) which may be useful for analyzing demand, need and use patterns. Combined with other information or in a modified form, such sources could provide essential insights about ECEC. This section provides a list of such potential data sources.

Census

Statistics Canada (Every 5 years)
Information on the number of children (population count by age) and the employment status and other characteristics of their parents is produced every five years (2001, 2006, etc.). This information comes from a very large sample (either a 100% sample every ten years or a 20% sample every five years of the entire population) and therefore can provide extremely accurate population counts for detailed geographical areas within Canada. There is, however, no data on ECEC or child care arrangements.

Labour Force Survey

Statistics Canada (Monthly)
This is the best data source for information on the labour force status and hours of work of parents. The survey covers about 60,000 households and collects information on labour force characteristics of Canadians including mothers by age of youngest child, leaves from employment, etc. While the labour force status of parents is collected on these surveys, there is insufficient information about the actual hours worked, including shiftwork to gain an understanding about how and how much child care is required. In 1981, a short survey of child care arrangements was conducted as a supplement to the Labour Force Survey; topics covered included use patterns for youngest child, child and family characteristics, family income, type of child care arrangement and cost of service, and reasons for child care use.

Survey of Labour and Income Dynamics (SLID)
Statistics Canada (Continuing)
This is a panel survey of employment experiences and incomes of families and individuals. There is no information about ECEC but there is data about entry/exit from maternity/parental leaves and about parental employment patterns. The SLID is good for evaluating changes over time in parental work patterns as children age.

Survey of Household Spending (SHS)
Statistics Canada (Annual)
This replaced the Family Expenditure Survey, commonly known as FAMEX. It collects information using a household survey about all household expenditures, including expenditures on child care, together with data on household labour force characteristics, income and other expenditures. There is currently very little detail on type of ECEC program used or for what purpose and there is no information about hours or quality characteristics of care.

Canadian Community Health Survey (CCHS)
Canadian Institute for Health Information (2000-2001)
This survey is designed to provide reliable cross-sectional estimates of health determinants, health status and health system utilization for 132 health regions across Canada. Each two-year collection cycle will be comprised of two distinct surveys: a health region-level survey in the first year with a total sample of 130,000 and a provincial-level survey in the second year with a total sample of 30,000. The target population of the CCHS includes household residents in all provinces and territories with the principal exclusion of populations on Indian Reserves, Canadian Forces Bases, and some remote areas. There will be one randomly selected respondent per household, although planned oversampling of youths will result in a second member of certain households being interviewed. For the first collection cycle, only those 12 years of age and over are eligible for selection although it is expected that in future cycles child-specific content will be included. Consideration could be given to using this survey as a basis for an ECEC parent survey.
CANADIAN DATABASES BY PROVINCES
British Columbia

[www.edudata.educ.ubc.ca/index.html](http://www.edudata.educ.ubc.ca/index.html) (EDUDATA)
[www.earlylearning.ubc.ca/](http://www.earlylearning.ubc.ca/)

Description of Databases

**BC Perinatal Database Registry (BCPDR)**

The BC Perinatal Database Registry (BCPDR) under the umbrella of the British Columbia Reproductive Care Program, is a comprehensive, province-wide perinatal database collected for the purpose of evaluating perinatal outcomes, care processes and resources, ultimately improving maternal, fetal, and newborn care. The registry collects, summarizes, interprets and reports on perinatal events, outcomes and care processes at a hospital, regional and provincial level. The scope of the database includes the collection of standardized antenatal, intrapartum, immediate postpartum and newborn data on all deliveries and births in British Columbia. Full provincial participation was achieved for the 2000/2001 fiscal year. The year 2006 marked the 6th year of full provincial data for the BCPDR.

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This report provides a baseline analysis of the state of early child development, its social and economic determinants, and the resources available for children 0-5 in Vancouver. The report is a prototype tool that communities can use to assess progress in improving outcomes for children’s health and development.

Population-based data on the development of kindergarten children is central to the report, using the Early Development Indicator (EDI) developed under the auspices of the Centre for Study of Children at Risk at McMaster University. The Report draws upon ground-breaking work in population health and human development of the Canadian Institute for Advanced Research, insights generated from the National Longitudinal Study of Children and Youth (Human Resources Development Canada/Statistics Canada), and approaches to measuring early...
child development highlighted in the Understanding the Early Years program (Human Resources Development Canada).

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Edudata Canada

Based in the Faculty of Education at the University of British Columbia, Edudata Canada acts as an information broker for data relating to BC’s K-12 school system. Edudata holds all BC Ministry of Education data from 1990 onwards, drawn from exam and test results, surveys, and other sources. It also holds some data from Statistics Canada, the Organization for Economic Co-operation and Development, the Early Development Instrument (EDI), and the School Achievement Indicator Program (SAIP).

While some of this data, such as Item-Level FSA Reports, data can be viewed on this site (see online tools under services for parents or educators), much of it is subject to privacy laws, and is therefore only available to qualified researchers. Much of this information is indexed in their data catalogues on website under Services for Researchers. There are two kinds of catalogues included: data catalogues and knowledge catalogues. Data catalogues provide metadata and/or detailed information about variables, definitions, and data collection time. Knowledge catalogues provide online tools for collaborators and practitioners to describe and share their practice, research methods and data.

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EDI: Human Early Learning Partnership (HELP)

The Human Early Learning Partnership (HELP) enriches data for the Early Development Instrument (EDI) a measure of school readiness with census socio-demographic and community asset data by geographic neighbourhoods. Using the EDI, HELP has collected child development data on physical, social, emotional, cognitive and communication domains for kindergarten children province-wide. The website mapping portal allows downloading of EDI maps and data at an aggregate level (e.g. school or neighbourhood). To maintain anonymity and group-measure status, all individual data collected is analyzed and reported only at an aggregate level. The EDI is a population-based measure for communities. There is no interpretation or assessment of individual information. All personally identifiable information collected is completely confidential.
INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Standardized antenatal, intrapartum, immediate postpartum and newborn data on all deliveries and births in British Columbia from 2001 onward (BCPDR)

Education and Child Care

- Physical Development
- Cognitive Development (EDI)
- Communication (EDI)
- Emotional Development (EDI)
- Social Development (EDI)

Health

- Perinatal events
Description of Databases

Manitoba Education, Citizenship and Youth (MECY) Database

This database contains assessment, evaluation, and enrolment information for students in the province of Manitoba. MECY is “charged with the responsibility for setting priorities and allocating funds” for the Province’s public and independent Kindergarten to Grade 12 (Senior 4) school system and for citizenship and youth initiatives (ECY Annual Report 2004-2005). The information collected through this process is used in “calculating school funding as well as to establish student demographic records, providing course registration data and to provide information on teaching activities” (ECY Annual Report 2004-2005).

The MECY database at Manitoba Centre for Health Policy (MCHP) consists of data received from the following three branches of Education for students enrolled in Manitoba schools. Further information can be found at: www.edu.gov.mb.ca/k12/assess/publications.html.

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Winnipeg School Division Database

Winnipeg School Division (WSD) Database contains information on students attending schools in one of the four school districts (North, South, Central and Inner City) that comprise WSD (formerly known as WSD #1). The largest school division of 6 divisions serving children in Winnipeg, WSD is responsible for providing educational programs and related services to a significantly multi-ethnic population.

The WSD database at MCHP contains records for students attending school in any of the four districts comprising the Winnipeg School Division (approximately 34,000 students from Nursery to Grade 12). As a subset of the Manitoba school population, much of the data overlaps with the MECY database. Additional work is ongoing to determine its viability as an alternate source of education information.

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Early Development Instrument (EDI), Healthy Child Manitoba

During the first year of implementation in 2002/03, 24 of 38 school divisions (about 8,000 Kindergarten students) completed the EDI. In 2003/04, 28 of 38 divisions (about 8,500 students) completed it. For the 2004/05 school year, 31 of 38 school divisions have completed the EDI. These results are available in the 2005 Early Childhood Development Progress Report to Manitobans. As of 2006/07 the EDI is to be collected province wide (about 12,000 students) every two years). To view a sample report, see: http://www.gov.mb.ca/healthychild/about/annual.html
The Manitoba Centre for Health Policy

The Manitoba Centre for Health Policy has developed a repository of anonymous population-based data that includes information on children's birth outcomes (e.g., low birth weight), mortality rates, health care use, and education levels. This repository also contains information on some of the measures that might influence these outcomes. It includes individual factors (e.g., chronic health conditions), family characteristics (e.g., residential mobility), school characteristics (e.g., classroom size) and neighbourhood features (e.g., average education level). By looking at how these factors relate to children's outcomes, researchers will be able to pinpoint some of the individual, family, school and community characteristics that contribute to or buffer against inequalities in health and functioning. They will also be able to identify which policy options, including health care delivery, have the greatest potential for reducing inequalities in child health and functioning.

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The Population Health Research Data Repository (PHRDR)

PHRDR housed at Manitoba Centre for Health Policy (MCHP) is a comprehensive collection of administrative, registry, survey and other databases primarily comprising residents of Manitoba. It was developed to describe and explain patterns of health care and profiles of health and illness, facilitating inter-sectoral research in areas such as health care, education, and social services. The administrative health database, for example, holds records for virtually all contacts with the provincial health care system, the Manitoba Health Services Insurance Plan (including physicians, hospitals, personal care homes, home care, and pharmaceutical prescriptions) of all registered individuals. MCHP acts as a steward of the information in the PHRDR for agencies such as Manitoba Health.
The Population Health Research Data Repository contains anonymized encounter-based records of individuals’ interactions with the provincial health care system. It is derived from information contained in the Manitoba Health Services Insurance Plan registry, and from health insurance claims routinely filed by physicians and health care facilities with Manitoba Health. Manitoba Health provides MCHP with copies of several files which have been identified as necessary to carry out MCHP deliverables, including the hospital file, medical claims file, long-term care file and the registry.

Over the years, MCHP has added to the health data to allow broader and more robust analyses of factors that affect health. For example, there are data from Public Access Census Data and Education and Training. Data exist in unlinked format and are only linked for specific projects which have been approved as described previously.

The entire population of the province is covered. Individuals covered by the Manitoba Health Services Insurance Plan, migration into and out of the province, and mortality can be traced from 1970 onward. Researchers can track groups of subjects through time in order to determine if individuals receiving a given intervention truly have no adverse outcomes, or if no adverse events appear to be occurring because the individual has left the province or died.

Although the data continue to belong to the parent organization, Manitoba Health for example, MCHP acts as a steward of the information, accessing and organizing files for specified research projects.

The Data Repository managed by MCHP housed at the University of Manitoba: Since the 1970s, Manitoba Health has provided copies of computerized health care utilization files to the University of Manitoba. All records deposited in the Repository have been processed by Manitoba Health to remove names and addresses while preserving the capacity to link records together to form individual histories of health care use. The Repository is central to the versatility and efficiency of research conducted by MCHP, and has served as a model for the establishment of repositories at the University of British Columbia and at the Institute for Clinical Evaluative Sciences in Ontario.

This repository has become a global model for research using linked databases. Linkages are conducted on anonymised information, respecting the highest standards of security, confidentiality, and protection of privacy. In a project funded by the Canadian Population Health Initiative, data on educational performance, area-level socioeconomic status (SES), and residency in Manitoba were linked together to examine educational outcomes by SES (Brownell et al., 2004; 2006; Roos et al., 2006).

Contact Information:
Manitoba Centre for Health Policy
Directors:
INDICATORS INCLUDED IN DATABASES

Demographics and Vital Statistics

- Family characteristics (WSD)
- Employment of parents and single/dual parent family (WSD)
- Birth outcomes (Healthy Child)
- Mortality rates (Healthy Child)
- Family characteristics (e.g., residential mobility) (Healthy Child)
- Neighbourhood features (e.g., average education level) (Healthy Child)

Education and Child Care

- Enrolment: individual student-level enrolment and demographic data collected annually for all grades, Kindergarten to Grade 12 (MECY)
- Physical Development (EDI)
- Cognitive Development (EDI)
- Communication (EDI)
- Emotional Development (EDI)
- Social Development (EDI)
- University entrance (WSD)
- Degree of parental participation in educational programming (WSD)
- Math skills (WSD)
- Language arts skills (WSD)
- Motor skills (WSD)
- Social/emotional development (WSD)
- Education levels (Healthy Child)
- School characteristics (e.g., classroom size) (Healthy Child)
Health

- Contacts with the provincial health care system, the Manitoba Health Services Insurance Plan (including physicians, hospitals, personal care homes, home care, and pharmaceutical prescriptions) of all registered individuals (PHRDR)
- Health care use (Healthy Child)
- Chronic health conditions (Healthy Child)

Child Welfare

- Participation in public and community programs (WSD)

Special Projects, Reports and Initiatives

**Manitoba Child Health Atlas 2004**

Inequalities in Child Health: Assessing the Roles of Family, Community, Education and Health Care (January 2003 - September 2007)

This is the website for The Manitoba Child Health Atlas 2004, published solely on the World Wide Web. The Atlas comes out of a 3-year project funded by the Canadian Population Health Initiative focusing on factors that contribute to inequalities in child health and well-being. The Atlas provides descriptive, population-based analyses of the health and educational outcomes of Manitoba children, at the level of health regions and sub-regions.
Nova Scotia

Health: http://pediatrics.medicine.dal.ca/clinical/neo_clinical.htm
(Maternal child health)

Description of Databases

Population Health Research Unit (PHRU) - Research Data Repository

PHRU maintains over 200 million records from provincial administrative health databases, clinical databases and survey databases on secure computing facilities at Dalhousie University. Near comprehensive information about insured health services delivered to residents of Nova Scotia from 1989 to present, as well as information related to determinants of health and health outcomes, postal code-based geographic mapping and national and provincial census and survey data. PHRU has also established linkages to a number of unique population-based clinical and registry databases.

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Ravin Randhawa, Research Analyst
Peter Nestman, Research Coordinator
Yan Wang, Programmer /Data Manager

Maternal Child Health Database

The Perinatal Epidemiology Research Unit (PERU) was founded by both the Department of Pediatrics and the Department of Obstetrics and Gynecology of Dalhousie University. The PERU consultation and analysis support service continues with Dr. Colleen O'Connell contributing to many research projects in the institution. Dr. A. Allen is working with colleagues in the Reproductive Care Program of Nova Scotia and the Population Health Research Unit to develop the Maternal Child Health Database. This will have links between the Nova Scotia Atlee Perinatal Database and other databases containing child health information, such as the Medical Services Insurance (MSI) database, the Canadian Institute of Health Information database and the Vital Statistics database, as well as specialty databases within Pediatrics and Obstetrics. Further information from the Perinatal Epidemiology Research Unit may be found in their annual report.

INDICATORS INCLUDED IN DATABASES
Demographics and Vital Statistics

- Census data (PHRU)

Health

- Insured health services (PHRU)
- Child health data
Description of Databases

Integrated Services for Children Information System (ISCIS)

The Integrated Services for Children Information System (ISCIS) is a case management software application supporting the Healthy Babies, Healthy Children Program, which oversees the needs of 130,000 Ontario newborns a year, ensuring they receive the services they need from birth to age six.

The Integrated Services for Children Information System (ISCIS) is a data system used for collecting information for the HBHC program. ISCIS 1.0 was implemented in July 1999 as a system of stand-alone databases in each of the 37 public health units. It was an Access database with visual basic programming. The health units routinely transmitted data to the MOHLTC as a requirement of the program. ISCIS data are collected and entered by public health units, who are custodians of the data. They are responsible for the accuracy and completeness of the program data, including the Parkyn Postpartum Screen and Larson Prenatal Screen. As a result, issues related to the accuracy of ISCIS data may be different across health units. Data comparisons across health units should not be made, unless the data collection methodology between health units is deemed comparable.

The Parkyn Postpartum Screen

This screen is generally applied in hospitals by maternity nurses and consists of a series of questions designed to identify factors associated with risk of parenting problems. Postpartum screening aims to reach all women (consenting) who give birth in Ontario, and is the main source of information in ISCIS. In addition to the Parkyn Postpartum Screen, there are a number of other HBHC Program screens and assessments that can be entered into ISCIS including: Larson Prenatal Screen, Brief Assessment, In-Depth Family Assessment, and Nipissing Screens (screens for 13 age stages). Because the Parkyn is designed so that only “yes” entries are checked, the “no” entries are impossible to distinguish from “non-response”. This is important because “non-response” entries may actually fall into the “yes” category and should be analyzed separately. The Region of Waterloo identified this “non-response” problem and has consequently redesigned its
Parkyn forms to add both “yes” and “no” responses, and completed additional training of hospital and public health nurses with consistent guidelines for data collectors. Waterloo analyzed their data in 2003 after modifying the Larson and Parkyn forms. Although they found that the majority of questions in the prenatal tool were fully completed, all of the questions on the Parkyn Postpartum Screen had more than 10% missing data in 2003. The Apgar score was particularly poorly completed, with 80% missing. In the case of smoking during pregnancy, data quality improved as a result of the changes. The percent missing decreased from 80% in 2001 to 3% in 2003. These data quality issues should be considered when analyzing ISCIS data, particularly from the ISCIS extract.

Perinatal Extract Program

Since retrieving information from ISCIS 1.0 was cumbersome, APHEO requested the MOHLTC to create a mechanism to extract health indicators from ISCIS. The Extract program was piloted by various health units in summer 2002, and released in final form to all health units in December 2002. The program allows users to extract non-nominal data from ISCIS in a flat file format that can be analyzed by statistical software programs such as SPSS. Although ISCIS itself was organized by families, the extract program creates a file organized by individual children.

The program made the following assumptions to do this:

- Many of the fields are optional in ISCIS. A record was created in the extract file if at least one of the optional indicators was populated.

- The number of total live births was extracted from the Reporting Statistics that were manually entered into ISCIS by the health unit. This number was obtained from hospitals and should reflect the number of live births for the health unit jurisdiction only. However, this may not be the case in all health units and deliveries of babies for families residing in other health unit jurisdictions may be mistakenly counted or counts of babies with the health unit area may be missed if born elsewhere. Home births would likely not be included in the total number of live births.

- In the event that a newborn was defined as a member of two different families, only the birth mother’s family was reported in the extract record. If the birth mother could not be determined (e.g., both personal caregivers were female), then both families were reported. Newborns reported more than once were flagged in the extract.

Monitoring reports provide aggregate process information such as the number of pregnant women screened with the Larson tool, number of families who scored 9 or greater on the Parkyn, etc. The ISCIS extract, however, is a specialized function that allows more in-depth analysis. For example, the ISCIS extract could be used to map high risk families by postal code to better understand geographical
patterns within a health unit.

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Provincial Health Planning Database (PHPDB)
Health Planning Branch, Ontario MOHLT

Health Planning System (HELPS)
Public Health Branch, Ontario MOHLTC

Both databases include vital statistics (births and deaths) For more information see:
www.torontohealthprofiles.ca/documents/torontohealthprofilessept22workshop_all.ppt

The strengths of these databases are the inclusion of country of birth, links of baby to mother for analysis of singleton LBW by age, parity and pregnancy type. The limitations of this database are that it is missing unregistered births, postal codes (potentially over 3%) and there is a two year time lag in data availability.

Original source: Ontario Office of Registrar General (ORG)
Distributed by:

  1. Provincial Health Planning Database (PHPDB), Health Planning Branch, Ontario MOHLTC
  2. Health Planning System (HELPS), Public Health Branch, Ontario MOHLTC

Livebirth Database

The Ontario Live Birth Database (whether accessed via the Health Planning System, HELPS; or the Provincial Health Planning Database, PHPDB) contains records of live births collected, compiled and stored by the Office of the Registrar General (ORG) of the Ministry of Consumer and Business Services. Statistics Canada performs final editing of the data for statistical use.
Live birth data are collected with the use of two legal documents:
  Form 1 "Notice of Live Birth or Stillbirth" and
  Form 2 "Statement of Live Birth".
Niday Perinatal Database (NPD)
https://www.nidaydatabase.com/info/index.shtml

The Niday Perinatal Database is a comprehensive internet-based database that uses the provincial CritiCall system as a platform, providing immediate access to real-time population-based perinatal data. The public health units that are part of Niday Perinatal Database of the Greater Toronto Area (GTA) are: Toronto Public Health; Durham Region Health Department; Halton Region Health Department; Regional Municipality of Peel Health Department; and York Region Health Services Department. As of April 2004, over 50 hospitals and midwifery groups are entering data into the Niday Perinatal Database, and more continue to join regularly. Approximately 80% of Ontario births are being captured as of 2004.

The database collects information on variables related to maternal, newborn and perinatal care characteristics, including information on details of births and obstetrical interventions.

The Child Health Network for the Greater Toronto Area (CHN)

In April 2003, the Child Health Network for the Greater Toronto Area (CHN), in partnership with the GTA Public Health and Perinatal Data Workgroup, implemented a standardized perinatal database for the GTA modeled after the PPPESO Niday Perinatal Database. The CHN is a partnership of community and hospital providers committed to building a more coordinated, seamless system of health service delivery for mothers, newborns and children across the Greater Toronto Area (GTA). For more information, see the web sites of PPPESO: www.pppeso.on.ca and CHN: www.childhealthnetwork.com

Institute for Clinical Evaluative Sciences (ICES)
www.ices.on.ca/webpage.cfm?site_id=1&org_id=26
Since its inception in 1992, ICES has played a key role in providing unique scientific insights to help policymakers, managers, planners, practitioners and other researchers shape the future direction of the Ontario health care system. Their work encompasses the assessment of care delivery, patterns of service utilization, health technologies, drug therapies and treatment modalities. Key to the knowledge produced at ICES is their ability to anonymously link population-based health information on an individual patient basis, using unique ICES identifiers that ensure the privacy and confidentiality of health information. Linked data allows researchers to obtain a more comprehensive view of specific health care issues, than could be achieved with unlinked data.

Contact Information:
Don DeBoer, Director, Data Management (Tel: 416-480-6189)
## Indicators Included in Databases

### Demographics and Vital Statistics
- Total number of live births (PHPDB & HELPS)
- Total number of live births per 1,000 population (PHPDB & HELPS)
- Crude birth rate (PHPDB & HELPS)
- Perinatal mortality rate (PHPDB & HELPS)
- Perinatal mortality ratio (PHPDB & HELPS)
- Stillbirth rate (PHPDB & HELPS)
- Perinatal Mortality (PHPDB & HELPS)

  - The total number of deaths of a fetus or infant between the end of the 20th week gestation and the end of the 6th day of life in a calendar year per 1,000 total births (live and still) in the same calendar year.

### Health
- Newborn screening (see above databases - extensive)

### Child Welfare
- Factors associated with parenting problems (ISCIS)
Special Projects, Reports and Initiatives

The Québec Longitudinal Study of Child Development (QLSCD)

www.cls.ioe.ac.uk/text.asp?section=00010001000500090011
www.jesuisjeserai.stat.gouv.qc.ca/default_an.htm

The Québec Longitudinal Study of Child Development (QLSCD) was designed with the express intent of furthering knowledge of child development. Its main objective has been to identify factors that, come into play during early childhood, affecting the social adjustment and academic performance of young Quebeckers.

The first round (i.e., the first year of Phase I) of the QLSCD was conducted in 1998 on a cohort of 2,120 Québec infants who were to be followed annually from 5 months to about 4 years of age. This representative sample included children (single births) born in Québec in 1997-1998.

So far, the data collected during this first phase (1998-2002) have enabled researchers to evaluate the influence of particular milieus (family, child care and the broader social environment) on various aspects of well-being. For instance, quite a few studies dealing with health, development (motor, social and cognitive), behaviour, diet, sleep, the family and economic environment, use of child care, etc., have already been performed. The publication of several of these was underwritten by the Direction Santé Québec (DSQ) of the Institut de la statistique du Québec (ISQ) (see the 24 issues published in the first two volumes of the QLSCD collection, which appeared in 2000, 2001, 2002, and 2003, and the four fascicles of volume 3, which appeared in 2004 and 2005). Note that the researchers, students and professionals working on this project are now pursuing a number of projects that use data collected during the first phase of the study.

The first Phase (0-5 years old), several direct measures of cognitive development were included as well as a number of health variables and anthropometric measures declared by parents.

The second phase of the QLSCD (2003-2011) extends the QLSCD 1998-2002 and will continue to collect required information using a computerized questionnaire, paper instruments and tests. The data collection will be carried out in four waves across Québec, each lasting about a month (from March to June): once a year until the children reach the second year of primary school (kindergarten, first and second years) and then biannually to the end of primary school (fourth and sixth years). The methodological specifications for the QLSCD 2003-2011 have been determined by the Institut de la statistique du Québec and
its partners (the ministère de la Santé et des Services sociaux, the ministère de la Famille, des Aînés et de la Condition féminine, the ministère de l’Éducation, du Loisir et du Sport, the Fondation Lucie and André Chagnon and academic researchers).

The children who have been followed for the past six years have now entered primary school. Starting in 2003, data that will help us understand developmental factors that favour academic success in primary school in light of children’s life experiences in early childhood were collected.
Appendix A: UNICEF Data for children 0-5

2006 MONEE STATISTICAL TEMPLATE

1. DEMOGRAPHIC INDICATORS
Population by age (by single year of age), males and females

1.B BIRTHS BY AGE GROUP AND MARITAL STATUS OF MOTHER

1.B.1. Total number of births by age of mother (of which:)
  1.B.1.1 Women age < 20 years
  1.B.1.2 Women age 20-24 years
  1.B.1.3 Women age 25-29 years
  1.B.1.4 Women age 30-34 years
  1.B.1.5 Women age 35+ years
  1.B.1.6 Unknown age

1.B.2. Total number of births to married women (of which:)
  1.B.2.1 Women age < 20 years
  1.B.2.2 Women age 20-24 years
  1.B.2.3 Women age 25-29 years
  1.B.2.4 Women age 30-34 years
  1.B.2.5 Women age 35+ years
  1.B.2.6 Unknown age

1.B.3. Total number of live births by age of mother (of which:)
  1.B.3.1 Women age < 20 years
  1.B.3.2 Women age 20-24 years
  1.B.3.3 Women age 25-29 years
  1.B.3.4 Women age 30-34 years
  1.B.3.5 Women age 35+ years
  1.B.3.6 Unknown age

1.B.4. Total live births to married women (of which:)
  1.B.4.1 Women age < 20 years
  1.B.4.2 Women age 20-24 years
  1.B.4.3 Women age 25-29 years
  1.B.4.4 Women age 30-34 years
  1.B.4.5 Women age 35+ years
  1.B.4.6 Unknown age

1.B.5 Average age of females at time of first birth

1.C NUMBER OF BIRTHS BY EDUCATION OF MOTHER
1.C.1 Total live births, of which to women with:
1.C.1.1 Primary or incomplete primary education
1.C.1.2 Lower secondary (basic) education
1.C.1.3 Upper -secondary (secondary) education
1.C.1.4 Tertiary education
1.C.1.5 Unknown education

Reference period: Year
Definitions:

- 1. Birth: use live births, if not available use total births and put a note in column "S".

- 2. Education levels recommended: primary education - ISCED 1, basic education - ISCED 1 and 2 together, secondary education - ISCED 3 and 4, tertiary - ISCED 5 and 6.

If data by national concepts cannot be reconciled with this classification please use national concept and note in column "S". If primary cannot be separated, leave row 1.C.1.1 empty.

Please note changes over the period in any of the above - birth or educational attainment - concepts.

1.D NUMBER OF VERY LOW AND LOW BIRTH WEIGHT NEWBORNS BY AGE GROUP OF MOTHER

1.D.1 Total live births <1500 grams

1.D.2. Total live births <2500 grams (of which:)
   1.D.2.1 To women age < 20 years
   1.D.2.2 To women age 20-24 years
   1.D.2.3 To women age 25-29 years
   1.D.2.4 To women age 30-34 years
   1.D.2.5 To women age 35+ years
   1.D.2.6 Unknown age

Reference period: Year
Definitions:

1) Births = Annual number of live births.
2) Very low birth weight newborns = weighing less than 1500 grams at birth.
3) Low birth weight newborns = those weighing less than 2500 grams at birth.

1.E TOTAL FERTILITY RATE
1.E.1 Total fertility rate

Reference period: Year
Definitions: Total fertility rate (TFR) = Computed as a sum of age-specific birth rates by single year age groups, 15-49 years. TFR represents the theoretical number of children that would be born to a woman in the course of reproductive years if subject to the rate of birth at each age observed in a given year.

1.F.1 Abortions by age group and marital status

1.F.1.1 Total number of abortions (of which:)
   1.F.1.1.1 By women age < 20 years
   1.F.1.1.2 By women age 20-24 years
   1.F.1.1.3 By women age 25-29 years
   1.F.1.1.4 By women age 30-34 years
   1.F.1.1.5 By women age 35+ years
   1.F.1.1.6 Unknown age

1.F.2. Total number of abortions by married women

Reference period: Year
Definitions: 1) Abortion = Annual number of legally induced abortions, including spontaneous and mini-abortions. 2) Married = Currently married or living in a common law relationship. Excludes separated, divorced, or widowed women.

1.G.1 Maternal mortality by age

1.G.1.1 Total number of maternal deaths
   1.G.1.1.1 Among women age < 20 years

Reference period: Year
Definitions: Annual number of deaths of women from pregnancy-related causes.

1.H.1 Infant and under 5 mortality by education of women

1.H.1.1 Number of deaths under 1 year
   1.H.1.1.1 Under 1 day
   1.H.1.1.2 1-6 days
   1.H.1.1.3 7-27 days

1.H.2 Number of stillbirths
1.H.3 Infant mortality rate (overall)

1.H.4 Number of deaths under 1 year among women with:
   1.H.4.1 Primary or incomplete primary education
   1.H.4.2 Lower secondary (basic) education
   1.H.4.3 Upper -secondary (secondary) education
   1.H.4.4 Tertiary education
   1.H.4.5 Unknown education

1.H.5 Number of deaths at age 0-4 among women with:
   1.H.5.1 Primary or incomplete primary education
   1.H.5.2 Lower secondary (basic) education
   1.H.5.3 Upper -secondary (secondary) education
   1.H.5.4 Tertiary education
   1.H.5.5 Unknown education

Reference period: Year
Definitions:

• 1. Infant mortality = annual number of deaths of infants under one year of age, excluding foetal deaths. Please note whether based on WHO concept of live births.

• 2. Under-5 mortality = annual number of deaths of children under five years of age, excluding foetal deaths.

• 3. Education of mother = please use concepts noted in Table 1.C

1.1 INFANT AND UNDER 5 MORTALITY BY CAUSE

1.I.1 Number of deaths under 1 year
   1.I.1.1 Infectious and parasitic diseases (A00-B99)
   1.I.1.2 Diseases of the respiratory system (J00-J98)
   1.I.1.3 Congenital malformations (Q00-Q99)
   1.I.1.4 Diseases of the perinatal period (P05-P96)
   1.I.1.5 External causes of mortality (V01-Y98)
   1.I.1.6 Unknown cause

1.I.2 Number of deaths at age 0-4
   1.I.2.1 Infectious and parasitic diseases (A00-B99)
   1.I.2.2 Diseases of the respiratory system (J00-J98)
   1.I.2.3 Congenital malformations (Q00-Q99)
   1.I.2.4 Diseases of the perinatal period (P05-P96)
1.1.2.5 External causes of mortality (V01-Y98)
1.1.2.6 Unknown cause

Reference period: Year
Cause of deaths = Individual classification numbers cited as per the ICD 10/1992 international classification of disease codes.

1.J MORTALITY BY GENDER AND AGE

1.J.1 Total deaths for males (of which:)
   1.J.1.1 < 1 year
   1.J.1.2 1-4 years
       1.J.1.2.1 1 year
       1.J.1.2.2 2 years
       1.J.1.2.3 3 years
       1.J.1.2.4 4 years

1.J.2 Total deaths for females (of which:)
   1.J.2.1 < 1 year
   1.J.2.2 1-4 years
       1.J.2.2.1 1 year
       1.J.2.2.2 2 years
       1.J.2.2.3 3 years
       1.J.2.2.4 4 years

Reference period: Year

1.M MARRIAGE AND DIVORCE

1.M.1 Annual number of marriages
1.M.2 Average age of females at first marriage
1.M.3 Average age of males at first marriage
1.M.4 Annual number of divorces
1.M.5 Annual number of children involved in divorce

Reference period: Year
Definitions:
- Marriages = annual number of legal marriages performed and registered, includes remarriages.
- Average age at first marriage = average age of females and males of those marrying for the first time.
• Divorces = annual number of final divorce decrees granted under civil law. Annulments and separations are excluded.

2. HEALTH INDICATORS

2.A CHILD AND MATERNAL HEALTH ACTIVITY COVERAGE

2.A.1 % of pregnant women receiving pregnancy consultations

2.A.2 % of births attended by trained personnel

2.A.3 % of women at term with anaemia

2.A.4 % of children immunised against:
   2.A.4.1 Diphtheria/Pertussis/Tetanus combined (DPT)
   2.A.4.1.1 Diphtheria/Tetanus combined (DT)
   2.A.4.1.1.1 Diphtheria separately (D)
   2.A.4.1.1.2 Tetanus separately (T)
   2.A.4.1.2 Pertussis separately (P)

2.A.4.2 Polio

2.A.4.3 Measles

2.A.4.4 Tuberculosis

Reference period: Year
Definitions:
• 1. Pregnancy consultations = Includes women followed by a physician from the first trimester of their pregnancy for a minimum of four consultations.

• 2. Births attended by trained personnel = births attended by physicians, nurses, midwives, trained primary health care workers, or trained traditional birth attendants.

• 3. For immunisations, please note age group, preferably 0-1 year or 0-2 years. If immunisation for diphtheria/pertussis/tetanus is administered combined enter data only in 2.A.5.1, if done separately, please enter data in specific categories.

2.B HEALTH SERVICES, FACILITIES AND STAFF

2.B.1 Annual number of outpatient visits/contacts, 1000s (of which:)
   2.B.1.1 Children (0-17 years)
2.B.2 Annual number of inpatient care admissions in hospitals (of which:)
   2.B.2.1 Children (0-17 years)

2.B.3 Number of primary care units

2.B.4 Number of hospitals

2.B.5 Number of hospital beds

2.B.6 Average length of stay in hospitals in days

2.B.7 Number of physicians (excluding dentists)

2.B.8 Number of dentists

2.B.9 Number of qualified nurses (of which:)
   2.B.9.1 Nurses of maternal and child health (MCH)

2.B.10 Number of midwives

Reference period: Year

2.C MORBIDITY AND DISABILITY

2.C.1 Diphtheria incidence

2.C.2 Pertussis incidence

2.C.3 Tetanus incidence

2.C.4 Measles incidence

2.C.5 Rubella incidence

2.C.6 Hepatitis incidence

2.C.7 Tuberculosis incidence

2.C.8 Total number of people registered with tuberculosis (end of the year) of which:
   2.C.9.1 Registered 0-14 years olds with tuberculosis (if other age group, please specify)
   2.C.9.2 Registered 15-19 years olds with tuberculosis (if other age group, please specify)
2.C.10  Sexually-transmitted diseases  (newly registered cases, of which:)
   2.C.10.1  Children (0-17) registered with sexually-transmitted diseases

2.C.11  Total number of new cases of syphilis among females
   Of which, number of cases by age group:
   2.C.11.1  10-14 years
   2.C.11.2  15-17 years
   2.C.11.3  18-19 years

2.C.12  Total number of new cases of syphilis among males
   Of which, number of cases by age group:
   2.C.12.1  10-14 years
   2.C.12.2  15-17 years
   2.C.12.3  18-19 years

2.C.13  Total number of new cases of gonorrhea among females
   Of which, number of cases by age group:
   2.C.13.1  10-14 years
   2.C.13.2  15-17 years
   2.C.13.3  18-19 years

2.C.14  Total number of new cases of gonorrhea among males
   Of which, number of cases by age group:
   2.C.14.1  10-14 years
   2.C.14.2  15-17 years
   2.C.14.3  18-19 years

2.C.14  Total number of new cases of chlamydial infections
   2.C.14.1  of which, number of new cases among 15-19 years old
      2.C.14.1.1  of which, number of cases among females 15-19 years old

2.C.15  Number of registered individuals with HIV, newly registered cases (of which:)
   2.C.15.1  Children (0-17) registered with HIV

2.C.16  Incidence of alcoholism and alcoholic psychosis (end of the year)
   2.C.16.1  of which, among 15-19 years old (if other age group, please specify)

2.C.17  Incidence of dependency upon narcotic and psychoactive substances (end of the year)
   2.C.17.1  of which, among 15-19 years old (if other age group, please specify)

2.C.18  Total number of registered disabled persons (end of year), of which:
   2.C.18.1  Children 0-17 (if other age group, please specify)

2.C.19  Children 0-17 newly registered as disabled during the year (if other age group, please specify)
Reference period: Year
Definitions: codes based on ICD 10/1992:


- 2. Children = 0-17 years, if other age group is used, please note in column "S".

- 3. Sexually-transmitted diseases include syphilis and gonorrhea; if others included, please list.

- 4. Alcoholisms and alcoholic psychosis, Dependency upon narcotic and psychoactive substances: cases registered with health care institutions

3. EDUCATION INDICATORS

3.A NURSERIES
(for children 0-2 or 0-3 years old, please specify relevant age group in your country)

3.A.1. Enrolment rate (please specify relevant age group in your country in column "S")

3.A.2. Total number of children in nurseries (of which:)

BY OWNERSHIP

3.A.2.1 In units with municipalities or central government
3.A.2.2 In units with enterprises or employers/private units

3.A.3. Total number of nurseries (exclude those mixed with kindergartens)
3.A.3.1 Municipalities or central government
3.A.3.2 Enterprises or employers/private units

3.A.4. Total capacity in nurseries (number of places)
3.A.4.1 In units with municipalities or central government
3.A.4.2 In units with enterprises or employers/private units

3.A 5. Total number of teachers

Definitions:
• Enrolment rate = Please use official published data and note whether rates are gross or net (i.e. whether rates are calculated with numerator and denominator referring to the same age groups or not).

• Nurseries = day care and boarding facilities which play a custodial role in caring for infants and very young children. Please note whether boarding nurseries (providing overnight care during workdays) exist and are included.

• Please give total number of children in nurseries, even if above 2/3 years old and exclude children placed in infant homes (i.e., without parental care)

3.B NURSERIES - KINDERGARTENS

3.B.1. Total number of children in nurseries-kindergartens (please specify relevant age group in your country in column "S", of which:)

BY OWNERSHIP
   3.B.1.1 In units with municipalities or central government
   3.B.1.2 In units with enterprises or employers/in private units

BY GENDER
   3.B.1.3 Number of girls enrolled

BY AGE
   3.B.1.4 < 2 years
   3.B.1.5 2 years
   3.B.1.6 3 years
   3.B.1.7 4 years
   3.B.1.8 5 years
   3.B.1.9 6 years
   3.B.1.10 7 years and older

3.B.2 Total number of nurseries-kindergartens
3.B.3 Total capacity (number of places)
3.B.4 Total number of teachers

3.C KINDERGARTENS (for children 3-5 or 3-6 years old, please specify relevant age-group in your country)

3.C.1. Enrolment rate (please specify relevant age-group in your country in column "S")

3.C.2. Total number of children enrolled in kindergartens (absolute numbers, of which:)
BY OWNERSHIP
  3.C.2.1 In units with municipalities or central government
  3.C.2.2 In units with enterprises or employers/in private units

BY GENDER
  3.C.2.3 Number of girls enrolled

BY AGE
  3.C.2.4 < 3 years
  3.C.2.5 3 years
  3.C.2.6 4 years
  3.C.2.7 5 years
  3.C.2.8 6 years
  3.C.2.9 7 years and more

3.C.3. Total number of days children absent from kindergarten (1000s)

3.C.4. Total number of units
  3.C.4.1 In units with municipalities or central government
  3.C.4.2 In units with enterprises or employers/in private units

3.C.5. Total capacity (number of places)
  3.C.5.1 In units with municipalities or central government
  3.C.5.2 In units with enterprises or employers/in private units

3.C.6. Total number of teachers

Definitions:
  • Kindergartens (ISCED category 0) are considered those institutions which
    serve a preparatory function for entering primary school, typically for children
    3-5 or 3-6 years old.
  • Net enrolment rate = Rate calculated based on the number of enrolments
    which correspond to nationally-defined age groups targeted for a certain
    educational level expressed as a percentage of the same population age
    group.

3.O. PUBLIC EXPENDITURES ON EDUCATION

3.O.1. Total public expenditures on education, of which on:
  3.O.1.1 Pre-primary education
  3.O.1.2 Basic education
  3.O.1.3 Primary education
  3.O.1.4 Lower secondary
  3.O.1.5 Upper secondary, general
3.O.1.6 Upper secondary, vocational
3.O.1.7 Upper secondary, technical
3.O.1.8 Tertiary

3.O.2 Total current expenditure, million local currency
3.O.2.1 Wages and salaries

1) For data on public expenditures, please refer to Section 4.4 of the 1995 UNESCO Yearbook

6.B BIRTH, MATERNITY AND PARENTAL LEAVE BENEFITS

6.B.1 Daily average number of women receiving maternity leave in the period

6.B.2 Total yearly amount paid on maternity leave benefit (in million national currency)

6.B.3 Total number of women receiving birth grant in the year

6.B.4 Total yearly amount paid on birth grants (in million national currency)

6.B.5 Daily average number of parents on parental leave

6.B.6 Total yearly amount paid on parental leave benefit (in million national currency)

Reference period: Benefit recipients = end of year. Expenditure data = annual.
Definitions:

• 1) Maternity leave benefit: available only for mothers and typically for a 3-6 months period. Please note if birth grant included.
• 2) Parental leave/benefit: typically available until the age of 1/2/3 years of the child; often fathers (or grandparents) are also eligible. Please note whether parents on unpaid leave days are included in 6.B.5

Please give country-specific details about maternity and parental leave benefits and birth grants in column "P".

6.D INSTITUTIONAL PLACEMENT OF AT-RISK CHILDREN

6.D.1 Total number of children in public institutional care (of which:)

BY GENDER
6.D.1.1 Number of girls
### BY AGE

- **6.D.1.2** Children 0-3 years
- **6.D.1.3** Children 4-17 years
- **6.D.1.4** 18 years and more

### BY TYPE OF INSTITUTION

- **6.D.1.5** Number of children in infant homes
- **6.D.1.6** Number of children in child homes, orphanages
- **6.D.1.7** Number of children in boarding schools (homes)
- **6.D.1.8** Number of children in social care homes
- **6.D.1.9** Number of children in institutions for physically/mentally disabled
- **6.D.1.10** Number of children in public care in other types of child institutions

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of disabled children in public institutional care</td>
<td>6.D.2</td>
<td></td>
</tr>
<tr>
<td>Number of orphans in public institutional care</td>
<td>6.D.3</td>
<td></td>
</tr>
<tr>
<td>Number of youth &gt;18 years of age in child institutions</td>
<td>6.D.4</td>
<td></td>
</tr>
<tr>
<td>Total number of children who were left without parental care during the year, of which:</td>
<td>6.D.5</td>
<td></td>
</tr>
<tr>
<td>Number of children who entered infant homes, orphanages, boarding homes for orphans and children without parental care, family type homes</td>
<td>6.D.5.1</td>
<td></td>
</tr>
<tr>
<td>Number of children who entered guardian care</td>
<td>6.D.5.2</td>
<td></td>
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<tr>
<td>Number of children who entered boarding schools or other educative institutions financed by the state</td>
<td>6.D.5.3</td>
<td></td>
</tr>
<tr>
<td>Number of children who left public care during the year</td>
<td>6.D.6</td>
<td></td>
</tr>
<tr>
<td>Average per child public expenditure in public institutional care (national currency, of which:</td>
<td>6.D.7</td>
<td></td>
</tr>
<tr>
<td>Per child expenditure on children in infant homes</td>
<td>6.D.7.1</td>
<td></td>
</tr>
<tr>
<td>Per child expenditure on children in child homes, orphanages and boarding schools</td>
<td>6.D.7.2</td>
<td></td>
</tr>
<tr>
<td>Per child expenditure on children in institutions for the physically/mentally disabled</td>
<td>6.D.7.3</td>
<td></td>
</tr>
<tr>
<td>Number of children in non-public residential care</td>
<td>6.D.8</td>
<td></td>
</tr>
</tbody>
</table>

2) Infant homes are public institutions which care for children 0-2 or 3 years old (and occasionally older children, please note if relevant).

3) Child homes, orphanages, boarding schools for children without parental care typically care for children from about 4 years until adulthood. Please note in column "S" whether those above 18 are included or not.
4) Please give country-specific details about boarding schools (homes) of general type in column S.

5) Institutions for the physically/mentally disabled should include homes for invalid children, dystrophic hospitals and boarding schools for children with disabilities.

6) Other types of institutions include SOS villages, homes of family type, etc. Please note types of institutions which are included.

7) Per child public expenditure = Includes both current and capital expenditures. If only partial data are available (or data are available by other institutional breakdown) please enter data and put note in column "S".

6.E SUBSTITUTE FAMILY CARE AND SERVICES FOR AT-RISK FAMILIES

6.E.1 Number of children cared for by adoptive parents (END OF YEAR)

6.E.2 Number of children cared for by foster parents

6.E.3 Typical monthly foster care allowance per child

6.E.4 Number of children cared for by guardians

6.E.5 Total number of adoptions (DURING THE PERIOD), of which
   6.E.5.1 Number of international adoptions
   6.E.5.2 Number of step-adoptions

Reference period: Benefit recipients = end of year. Expenditure data = annual. Definitions: 1) Foster/guardian parents: substitute care provided by relatives or non-relatives on a short- or long-term basis.
2) Step-adoptions: Typically occurs when the parent of a child remarries and the new spouse legally adopts the step-children.
3) Please give country-specific details about foster care allowances in column S.

6.F CRIME AND JUVENILE JUSTICE

6.F.1 Total number of registered crimes (of which:)
   6.F.1.1 Number of violent crimes (of which:)
      6.F.1.1.1 Number of homicides

   6.F.1.2 Crimes against children and youths
      6.F.1.2.1 Number of cases of nonpayment of alimony (please note if included in 6.F.1.2)
6.F.1.3 Number of crimes committed by or with the participation of juvenile offenders (of which:)
   6.F.1.3.1 Violent crimes
   6.F.1.3.2 Property crimes
   6.F.1.3.3 Other (please specify)

6.F.1.4 Number of homicides committed by or with participation of juveniles (of which:)
   6.F.1.4.1 Number committed by juvenile males

6.F.2 Total number of convicted persons, of which
   6.F.2.1 Number of juveniles (of which:)
      6.F.2.1.1 Number of males convicted

6.F.3 Total number of those incarcerated for criminal offenses (of which:)
   6.F.3.1 Number of juveniles incarcerated (of which:)
      6.F.3.1.1 Number of juvenile males incarcerated

6.F.4 Total number of convicted children/juveniles in correctional/punitive institutions (of which:)
   6.F.4.1 Children/juveniles in residential schools/correction institutions at the end of the year
   6.F.4.2 Sentenced children/juveniles in prisons (result of criminal sentencing) at the end of the year

6.F.5 Number of children in unlocked social (behavioral) rehabilitation centres at the end of the year

6.F.6 Per child expenditure on children in correctional institutions/prisons

Reference period: End of year or during period

Definitions:

1. Juvenile offenders = age 14-17 years. If other, please specify

2. Violent crimes include (homicide or attempted homicide, forcible rape, or aggravated assault)

3. Please provide country-specific definitions regarding criminal cases against children and youth, typically included child abuse, exploitation of children, and other crimes in which the victim was a minor.

4. Sentencing rates do not include administrative sanctions

5. Incarcerated = in prisons, jails, work camps, etc.

6. Children = 0-17 years
7. Correctional institutions = punitive institutions including prisons, work camps etc. where children below 18 are placed either through court or administrative decisions.