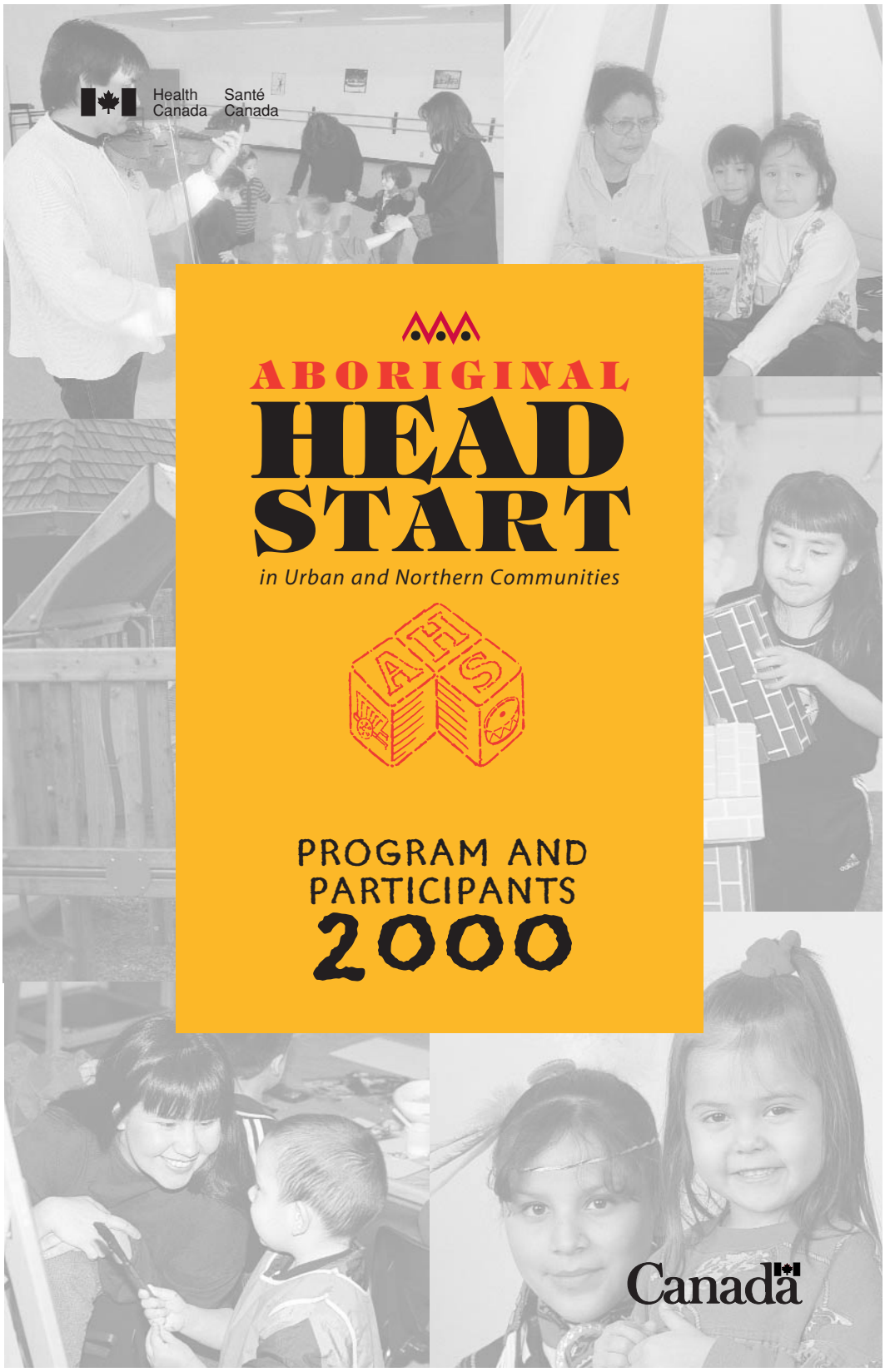

Health Canada Santé Canada

ABORIGINAL HEAD START

in Urban and Northern Communities

PROGRAM AND PARTICIPANTS 2000

Canada

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For additional copies, please contact:

Aboriginal Head Start
Childhood and Youth Division
Health Canada
Tunney's Pasture
Jeanne Mance Building
Postal Locator 1909C2
Ottawa, Ontario
K1A 1B4

Enquiries in English: (613) 952-5845
Enquiries in French: (613) 952-5845
Fax: (613) 941-5492

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INTRODUCTION

Aboriginal Head Start in Urban and Northern Communities

Aboriginal Head Start (AHS) is a Health Canada-funded early intervention program for First Nations, Inuit and Métis children and their families living in urban and northern communities. The principal goal of AHS is to demonstrate that locally controlled and designed early intervention strategies can provide Aboriginal children with a positive sense of themselves, a desire for learning and opportunities to develop fully as successful young people. AHS supports the spiritual, intellectual, physical and emotional growth of each child and supports parents as a child's first and most influential teacher.

AHS is providing a focal point for non-reserve-based Aboriginal communities to organize themselves around the needs of their children and to revitalize Aboriginal culture and language. Immense gratitude goes out to the sites that participate in evaluation activities each year, and to the stakeholders and sponsors who assist in the process. The AHS National Office and the National AHS Council acknowledge the amount of effort and time-consuming nature of participating in evaluation activities. The success of AHS is based firmly on the hard work of these determined individuals who advocate for and strive to enrich the lives of the thousands of Aboriginal children and families participating in AHS in urban and northern communities each year.

Program and Participants 2000

This report is the second in a series of annual process evaluation survey results for the Aboriginal Head Start (AHS) Program in Urban and Northern Communities. It presents key findings of the National Administrative and Process Evaluation Survey 2000. The National

Administrative and Process Evaluation Survey collects data regarding characteristics of the program and its participants, project administration and coordination, program components and the various activities associated with them, and program needs and finances. A National AHS Impact Evaluation is in development and will be the mechanism through which AHS will determine the impact the program is having on children, parents and the community. The survey results highlighted here are instrumental in developing the National Impact Evaluation.

The survey used in 2000 is similar to the one completed in 1999 (the results of which were published in 2000 in the document Children Making a Community Whole: A Review of Aboriginal Head Start in Urban and Northern Communities). Changes were made to the survey in 2000 to improve clarity and to secure more information. A pilot test of the revised survey was conducted to obtain input from projects regarding the changes, and further adjustments were made in response to feedback from the pilot sites regarding questions that were difficult to understand. More detailed information was gathered in 2000 to better understand how programs are delivered differently in diverse settings (e.g. urban, remote, Inuit).

The activities and programming of AHS sites are evolving with time and sites are incorporating what works best for them. Respondents were asked to describe what has changed in the way they deliver the six components of the AHS program. Data from the survey in 2000 builds on what was learned about the program in 1999 and continues to show impressive accomplishments and solid commitment to the program in Aboriginal communities.

THE PARTICIPANTS

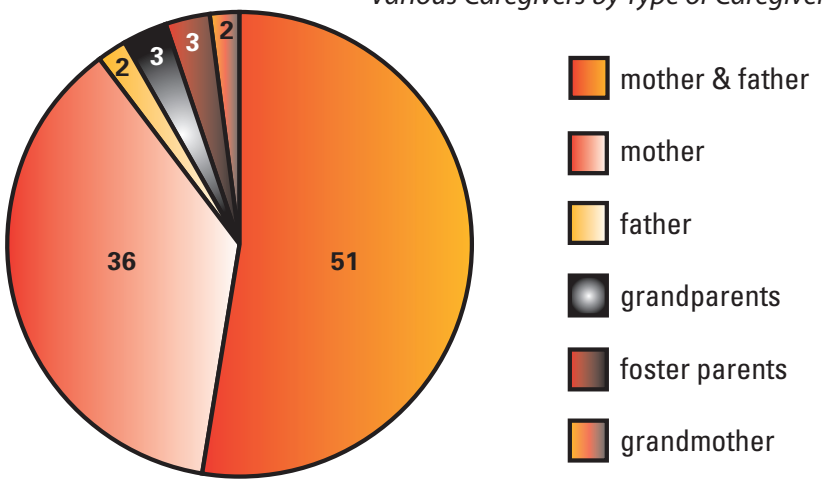
The Children

A total of 3,126 children enrolled in AHS in 2000. Sixty-seven percent of participating children have had no other early intervention programming before attending AHS. The bulk of participants are three to five years old although some projects also serve two and six year olds. The age distribution of children participating in AHS is presented in Figure 4. Of the total enrolled, 568 children, or 18 percent, speak an Aboriginal language fluently.

Nationally, 53 percent of the children enrolled in AHS are children from First Nations backgrounds, 28 percent are Métis and 18 percent are Inuit. In urban sites, 80 percent of participants are First Nations, 14 percent are Métis and three percent are Inuit. In remote sites, 46 percent are Inuit, 27 percent First Nations and 23 percent are Métis. In 36 percent of cases, children live at home with their single mother.

FIGURE 1

Percent of AHS Children Who Live With Various Caregivers by Type of Caregiver



Eighteen percent of children enrolled in AHS require greater-than-normal staff time as a result of a special need. Speech and language delays are the most commonly diagnosed special need among AHS children. To address the challenges caused by special needs, over half of the sites do the best they can without special training and community services. Seventeen percent of sites ensure all staff gets some sort of training to deal with special needs. Twenty percent of sites have a visiting professional consult with the site on a weekly basis and 49 percent have this opportunity on a monthly or yearly basis. There are no sites with a special needs worker on the team. Sites identify Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) as the most challenging special need to address.

The Parents

Parents and families are active contributors to the program through their involvement in all aspects of program development and delivery. AHS intends for parents to complete the program with increased confidence and a deeper understanding of their child's healthy development.

Fathers are becoming more involved in AHS programming. Sixteen percent of sites have a targeted strategy to reach out to fathers. Three AHS sites have a Dads Can Group, six sites specifically ask fathers for help in the centre, and eight sites involve fathers in program planning.

Respondents were asked to identify the characteristics of parent participants that present challenges that sites must deal with while delivering the AHS program. A lack of parenting skills and issues related to living in poverty are the most common challenges that parents face, according to AHS sites. Other common ones include issues related to family alcohol or drug addiction and family violence.

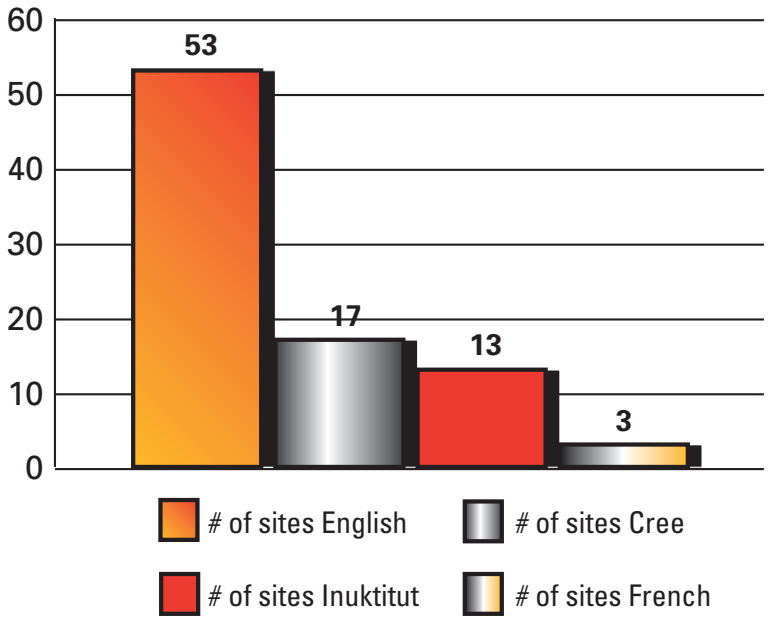
THE SIX PROGRAM COMPONENTS

Aboriginal Culture and Language

There are 24 Aboriginal languages formally taught in AHS sites across Canada. Cree is taught in 52 sites, Ojibway in 14 sites, Michif in nine sites, Inuktitut in eight sites, Saulteaux in seven sites and Mi'kmaq in three sites. Aboriginal languages are used daily in 80 percent of sites. In Inuit communities, 82 percent of sites use an Aboriginal language as their primary language of instruction. Figure 2 presents the most commonly used primary language(s) of instruction used in AHS sites.

FIGURE 2

Primary Language of Instruction



In the past year, 34 sites have expanded their use of elders and cultural resources. Eleven sites changed their team to include a culture and language specialist, four sites created culture and language classes for parents, and another four sites have increased the number of special guests and field trips.

Education and School Readiness:

There was a dramatic increase in the frequency with which parents are encouraged to help children with academic learning over the past year. In 1999, 68 percent of sites indicated they rarely or never did this, but in 2000, 71 percent of sites now report this is a daily or weekly activity. There has also been an increase from 55 percent in 1999 to 89 percent in 2000 in the number of projects that provide teaching materials for parents to use at home on a daily, weekly or monthly basis.

Attention to evaluation and change is most often paid in the education and school readiness component. Formal standardized developmental assessment tools are being used in well over half of the AHS sites. Sixty-eight AHS sites have made changes to the education and school readiness component of their program to: better stimulate child interest; focus on language skills; include more field trips; involve elders more; and increase communication with staff in the local school.

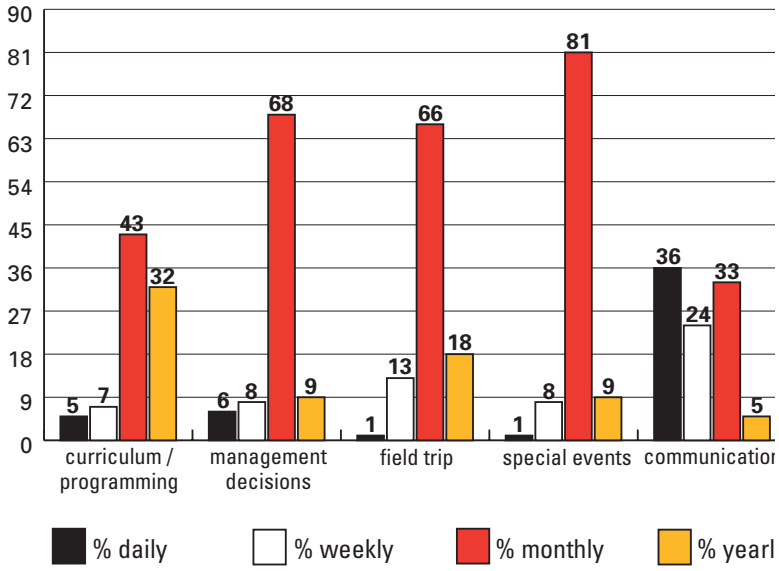
Parental Involvement:

Forty-nine percent of sites report an increase in parental participation over the last 12 months, yet 88 percent report difficulty getting parents involved. Substantially more parents are involved in decision-making roles (i.e. staffing and evaluating the program). In 84 percent of sites, parents participate on parent councils that oversee the delivery of the program. Inuit and remote sites have increased the number of sites with a parent council. However, the

number of sites with a parent council in urban sites has decreased slightly. Communicating with parents on a daily basis has dropped considerably from 90 percent of sites in 1999 to 36 percent in 2000, but has risen in frequency on a weekly and monthly basis from 10 percent of sites in 1999 to 57 percent in 2000.

FIGURE 3

Frequency of Parental Involvement in Various Activities[1]



Changes made to the parental involvement component over the past year were minor. Five percent of sites added or increased their use of home visits to encourage parents to become involved, while four percent improved their communication with parents. Other sites increased their use of potluck dinners and policies and outreach efforts directed at fathers. As an area of ongoing challenge in the program, evaluation data points to the need for more focus and resources dedicated to parental involvement (e.g. to provide for wide use of home visiting).

[1]When the percent of sites reporting does not equal 100 percent, the difference equals the number of sites reporting that they never engage in these activities.

Health Promotion:

Over 40 percent of sites provide information on child development and health services to parents at least weekly. Approximately a fifth of sites offer monthly workshops for parents and information on issues like substance abuse, child development, immunization, and health services. The most popular daily health promotion activities with children are: developing fine and gross motor skills in 96 percent of sites; participating in physical activity in 79 percent; teaching the children the importance of dental hygiene, seeing a dentist and learning about the role of a dentist in 77 percent; and teaching about the importance and effects of foods in 70 percent of sites.

Changes that have been made in the past year to the health promotion component involve an increase in the involvement of nurses/professionals in 17 percent of sites, and improvements in hygiene related education in 12 percent of sites. Seven percent added parent classes or workshops. Some other sites added health fairs and clinics, healthy baby/child programs and more nutritious snacks and meals.

Nutrition:

The most common means of promoting nutrition remains providing food and teaching the difference between healthy-versus-junk foods. Ninety-six percent of sites provide food to participants each day. Many sites focus on the nutritional value of Aboriginal foods and actively gather and prepare them with participants.

Of the 53 percent who made changes to the nutrition component of the program, 23 sites report initiating menu planning to improve the menu, 11 sites added potluck dinners and collective kitchens, six sites now offer food preparation workshops, and four sites increased parental involvement in this

component. A smaller number of sites reported changes through more partnerships, more resources or staff, initiating a food bingo, and changes to the curriculum to include nutrition.

Social Support:

Social support is most often offered to families through providing information and referrals and developing networks, and less frequently through other types of support such as home visits, toy lending libraries, and clothing exchanges. Most AHS sites try to ensure that parents are made aware of local community-based social services.

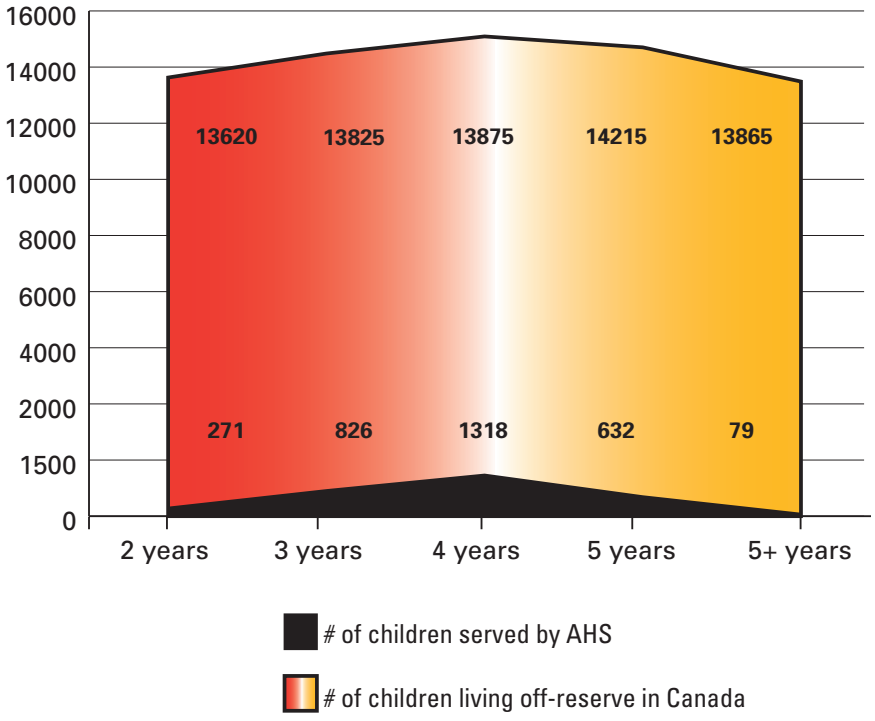
Forty-six percent of sites organize parent self-help groups on a monthly basis, 12 percent on a weekly basis and 11 percent on a daily basis. Individualized social support is often offered through home visiting, although the frequency with which AHS sites do home visits varies considerably. Home visits occur daily in small communities, and remote and Inuit communities were least likely to do home visits on a regular basis or at all. Most types of AHS communities do either monthly or yearly home visits. Overall, 65 percent of sites do either monthly or yearly home visits and 11 percent never conduct home visits.

THE REACH OF THE PROGRAM

Aboriginal Head Start currently reaches approximately seven percent of its target population. According to 1996 Census data, there are 41,915 three-to-five-year-old Aboriginal children living in urban and northern communities across Canada (the primary target group for AHS) with 2,776 enrolled in Aboriginal Head Start in urban and northern communities.

FIGURE 4

Aboriginal Children Served by AHS Compared With the Number of Aboriginal Children Living Off Reserve in Canada by Age (1996 Census)



There are now 114 AHS sites in eight provinces and all three northern territories. AHS sites located in remote communities account for 35 percent of the total projects, while 65 percent are located in non-remote communities.

Sixty-eight percent of projects operate ten months of the year and 24 percent operate year round. The average number of days attended per week by the children is four and the average maximum number of children that can be enrolled is 37. Eighty-nine percent of projects run half-day sessions.

Sixty-four percent of all AHS sites report that they are unable to enroll all the children in the community in need of AHS. In 2000, sites were asked which conditions would rank a child's family as a first priority for enrollment. Sixteen sites give priority to low income families, 13 sites use a first come-first serve policy, 12 sites rank referrals from human service agencies first, and 11 sites rank single parents as a top priority. Sites were also asked how many more children they could enroll in their current facility if they had enough space, employees and money. Forty-eight sites indicate that they could serve an additional 1,223 children with the additional resources to do so.

THE PROJECT TEAM, ADMINISTRATION AND FINANCES

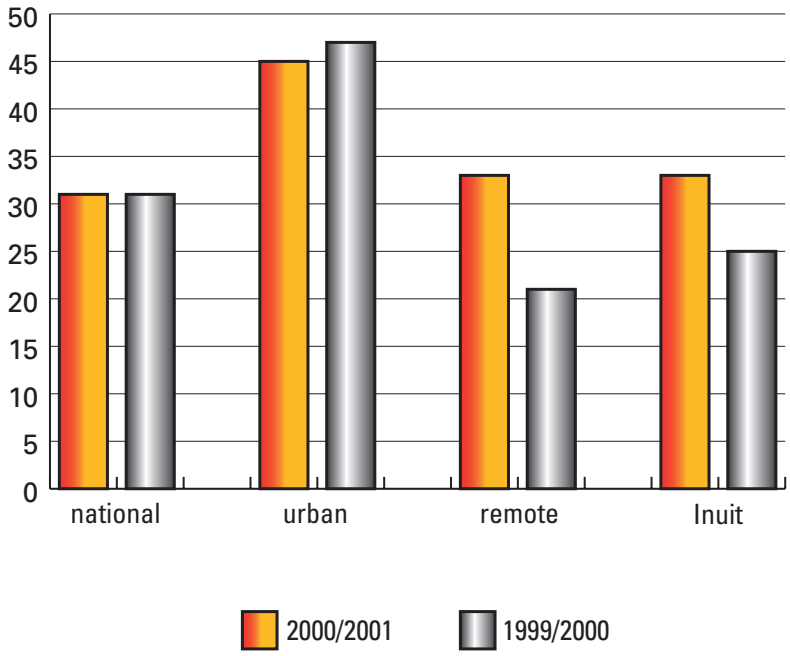
The Team

Aboriginal people occupy the majority of full and part time positions in AHS sites. The overall AHS team is now 89 percent Aboriginal. This is an increase from the 71 percent reported in 1999. Ninety-one percent of teachers, and 83 percent of Early Childhood Education certified team members are Aboriginal.

Of the staff members working directly with children, 31 percent are trained in Early Childhood Education (ECE). In urban communities, 45 percent of the AHS staff is ECE trained. In remote and Inuit communities, the number of staff that is ECE trained rose to 33 percent in 2000. In addition to ECE trained staff, 27 percent of the overall AHS team holds a graduate or undergraduate university degree. AHS sites consistently identify training for staff and parents as an area of need in the program.

FIGURE 5

Percentage of AHS Teams with ECE Training Broken Down by Community Type



In any given month, family members, elders, community members and cultural teachers contribute over 10,000 volunteer[2] service hours. Each project receives an average of 108 volunteer hours, which is down from 214 in 1999.

Project Administration and Finances

Friendship Centres are the most common sponsors of AHS projects (in 29 percent of sites) followed by incorporated groups of parents in 20 percent of sites, up from 14 percent in 1999.

[2]Volunteer is defined as a parent, guardian, caregiver, extended family member or adult in a community who is regarded as a caregiver who participates in an AHS site and neither directs or delivers a part of the program.

Staff salaries continue to account for the bulk of AHS sites' budgets. There is a wide variability in total salary costs when examined by community type, with a high of $144,427 in urban areas to a low of $71,366 in Inuit communities. A substantial proportion of costs associated with rent, mortgages, property costs, administration and transportation were also higher in large urban centres and lowest in Inuit communities. Costs associated with class supplies, however, were higher in Inuit communities and lowest in urban centres. Costs of honoraria, contracts and employee travel were also highest in Inuit communities and lowest in urban centres.

Health Canada allocations for AHS site's budgets vary widely with a minimum of $2,797[3] and a maximum of $456,150. The majority of sites receive between $200,000 and $250,000 annually, followed closely by sites that receive between $150,000 and $200,000.

AHS continues to receive support from other funding sources including other federal departments, provincial, municipal, hamlet, or Aboriginal governments, private granting foundations and fundraising efforts. A total of $1,329,351 was received from all other funding sources during the past fiscal year. This is down from the $3,058,627 received in 1999, but, it continues to represent an impressive contribution to the program. Provincial and territorial governments were the largest financial contributors to the program, followed by Aboriginal governments and other federal departments. Remote and Inuit AHS communities tend to receive more funding from other sources than urban and non-remote AHS communities.

Generous contributions are made via donated goods and services, the estimated value of which was $720,190. Remote, small, mid-sized and Inuit communities receive more donated goods and services, as well as volunteer time.

The combined value of donated goods and services and donated funds in 2000 was $2,049,861. Added together, a total of $5,874,861 has been donated to the AHS program in 1999 and 2000.

[3]In 1999, an agreement was made between Health Canada and the Kativik Regional Government in Nunavik, northern Quebec, which allowed all of Nunavik's child care centres to provide the Aboriginal Head Start Program to the children. Health Canada funding (initially intended for two AHS sites) in this region is divided among these centres. As a result, Health Canada funding to AHS sites in Nunavik is lower on a per-site basis because most funding comes from other sources.

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