Health Canada Santé Canada

ABORIGINAL HEAD START INITIATIVE

CHILDREN MAKING A COMMUNITY WHOLE:

A Review of Aboriginal Head Start In Urban and Northern Communities

Canada

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INTRODUCTION

Aboriginal Head Start (AHS) which is funded by Health Canada, is an early intervention program for First Nations, Inuit and Métis children and their families living in urban centres and large northern communities. In 1998, a major expansion of Aboriginal Head Start to First Nations communities on reserve began. Aboriginal Head Start projects typically provide half-day pre-school experiences that prepare young Aboriginal children for their school years by meeting their spiritual, emotional, intellectual and physical needs. All AHS sites provide programming or activities in each of the six AHS component areas: culture and language; education; health promotion; nutrition; parental involvement; and social support.

Generally, AHS projects operate September to June, four days per week, with 30-40 children 3-5 years old, in morning and afternoon sessions in a structured pre-school environment. Aboriginal Head Start projects are run by locally managed Aboriginal non-profit organizations. Parents participate in the management and operation of their children's programs.

Aboriginal Head Start has generated enthusiasm and passionate commitment among community participants - the parents, project staff and volunteers that have initiated projects and are keeping them going. Community participants have told Health Canada that:

- Aboriginal Head Start has provided Aboriginal communities and organizations with their best opportunity to collaborate;
- Aboriginal Head Start has focussed community energies on working together for the lives of children; and
- Aboriginal Head Start has improved the lives of thousands of Aboriginal children and families.

The program began in May 1995 with a four-year pilot phase (1995-96 to 1998-99) and has ongoing funding of $22.5 million annually. In January 2000, there were 112 urban and northern AHS sites, in eight provinces and three northern territories. This is an increase from the 98 sites funded in 1998-99, due to a new agreement with the Kativik Regional Government in Nunavik, northern Quebec, that will see all of its child care centres eventually offering full Aboriginal Head Start programming.

Since the beginning of the program, Health Canada and individual project sites have been committed to evaluation. All projects are required to engage in evaluations of Aboriginal Head Start (Urban and Northern) activities. At the national level, an evaluation framework was approved in 1997. The framework commits the program to conduct national process and impact evaluations. A design for the Process Evaluation was developed over the next year. This document reports on the results of

the first process evaluation, or 'administrative survey,' in 1999. The information in this document was collected from 96 of the 98 urban and northern AHS sites operating in the 1998-99 school year. The majority of projects were in their second or third year of operation at this time. A questionnaire was mailed to all sites by the AHS National Office in Ottawa, and local projects were given four weeks to respond. Respondents included project directors, instructors, sponsors, parents and others intimately involved in program delivery. Impact evaluation work is scheduled to commence in 2000.

After the completed questionnaires were received from AHS sites, Kishk Anaquot Health Research was contracted to analyse the data. Kim Scott and Debbie Clark produced the analyses and charts that appear in this report.

This report highlights the results and closely follows the structure of the survey with a few minor changes. The report describes background information, team characteristics, project administration and co-ordination, program participants and their communities, program components and the various strategies and plans associated with each, and, last, but certainly not least, program needs and finances. Comparisons have been made with data from other sources wherever possible.

A larger document called A Report of Process Evaluation Survey Results presents the complete results of the process evaluation survey. It was also prepared by Kishk Anaquot Health Research. This report is a summary of highlights taken directly from that document.

Data from the first process evaluation shows impressive accomplishments in Aboriginal Head Start communities. In the pilot phase, 98 communities developed facilities and operational programs. Most programs operate at capacity enrolment, and are demonstrating that local Aboriginal community development and management can build effective comprehensive early childhood programs.

The AHS National Evaluation is governed by an Evaluation Steering Committee. When the data contained in this report was compiled, the members of the committee were:

Linda Arkwright, *National AHS Committee*
Richard Budgell, *National Program Manager*
Kathleen Hunter, *Program Consultant Alberta/NWT Regional Office, Health Canada*
Odette Johnston, *Manager, Aboriginal Head Start On Reserve, Medical Services Branch, Health Canada*
Lynne Robertson, *Evaluation Analyst, AHS (Urban and Northern Communities), Health Canada*
Amy Bell, *National Evaluation Team for Children, Health Canada*
Esther Kwavnick, *Associate Director Childhood and Youth Division, Health Canada*
Lee Morrison, *Statistics Canada*
Robert Pelletier, *Policy and Consultation Branch, Health Canada*
Richard Veevers, *Statistics Canada*
Brian Ward, *Director, Childhood and Youth Division, Health Canada*

This stage of the evaluation was managed for Health Canada from May to August 1999 by Valerie Galley, and, since August 1999, by Lynne Robertson, both of whom deserve immense credit for seeing the report through to completion. Finally, our enormous gratitude goes out to the Aboriginal Head Start sites that dedicated the required time to completing the evaluation questionnaire, and that continue to dedicate themselves, day after day, to offering a high-quality pre-school program to Aboriginal children and families.

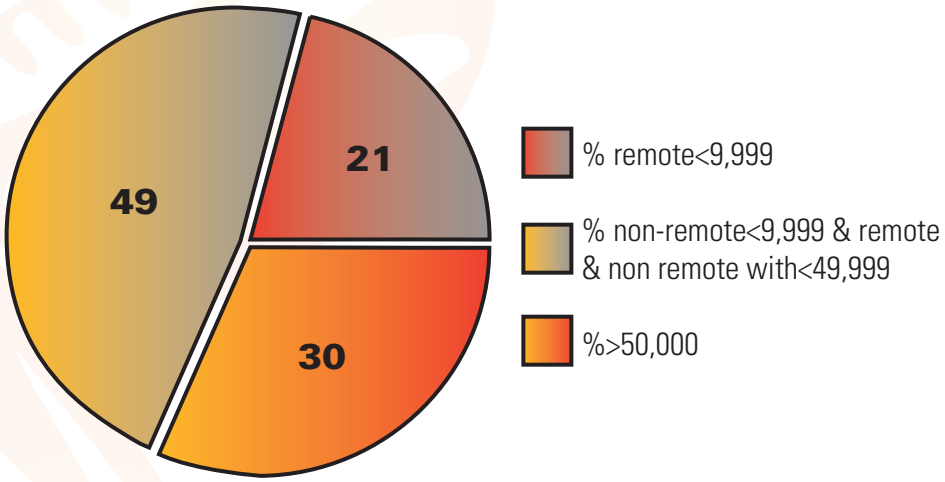
Richard Budgell
National Program Manager

Projects, Children and Families

Thirty percent of all projects are in urban centres, 21 percent in remote locations and 49 percent in non-remote centres with less than 49,999 people. A total of 3,236 children are enrolled in AHS. Boys and girls participate in about equal numbers, with the highest percentage of participants being four years old.

FIGURE 1

AHS Projects by Community Size and Remoteness



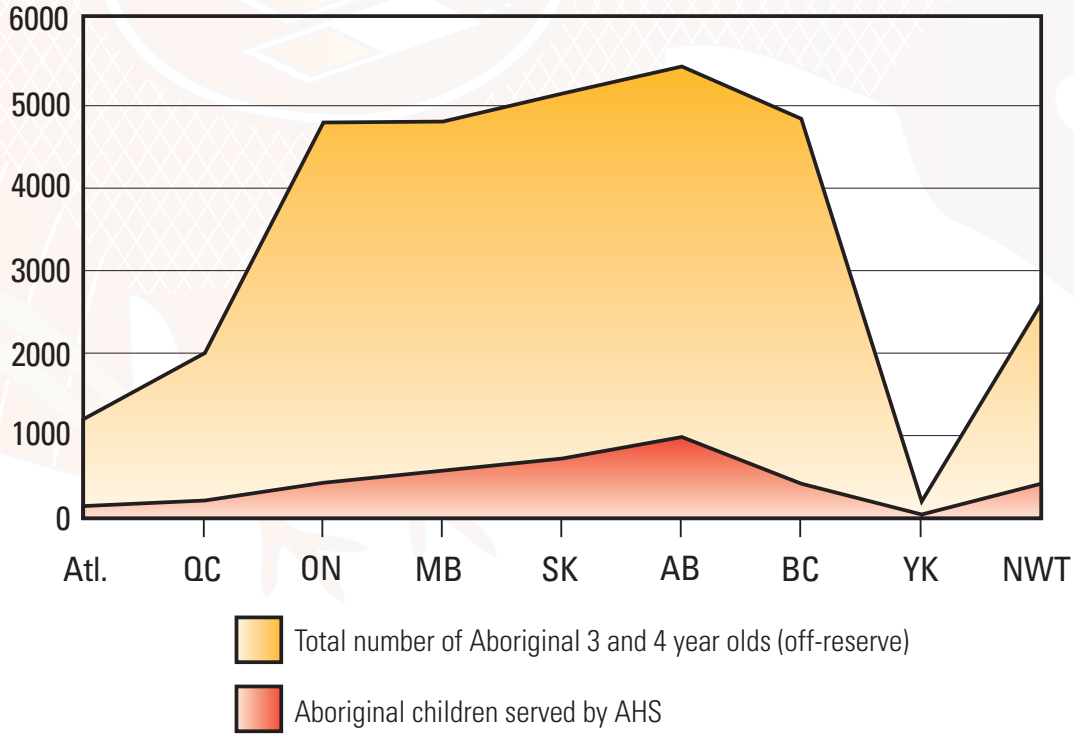
Over 600 children are on waiting lists for AHS, most of whom will wait about 7 weeks to be accepted. The vast majority of programs (88%) have intake procedures that may include interviews, home visits, applications and other printed material for parents. The number of children on waiting lists is not a full indication of the degree of need for the program. Statistics Canada's 1996 Census numbers show that there are more than 27,000 three and four year old Aboriginal children living off-reserve. Even operating at nearly full

capacity, as was the case in 1999, the program is able to accommodate only a small percentage of these children, as indicated in Figure 2.

About 30 children participate in AHS on any given day in any given project. Almost a fifth (17%) require greater than normal staff time, mostly for

FIGURE 2

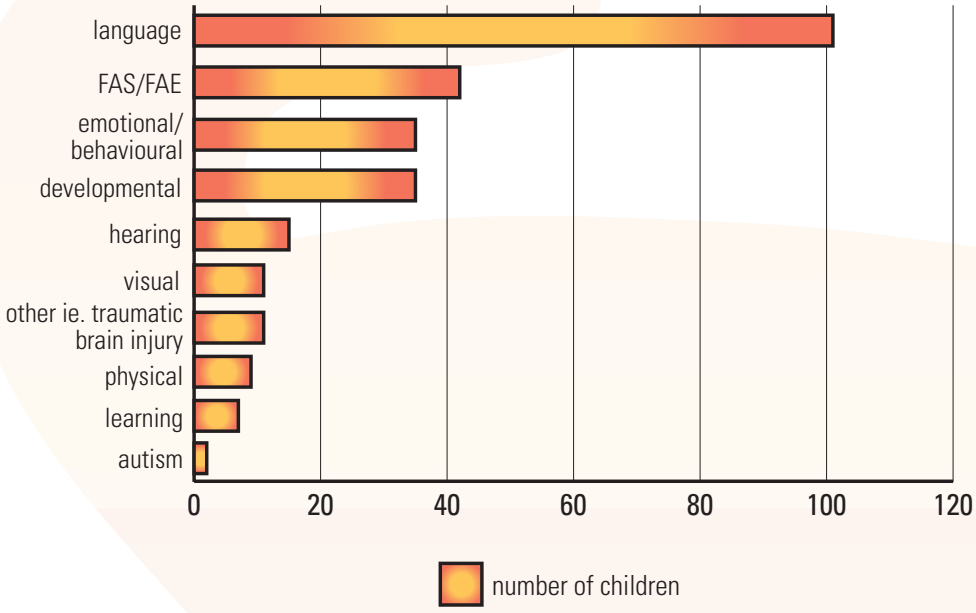
Children Served by AHS and Total Number of Aboriginal 3 and 4 Year Olds (off reserve) by Region



language-related, FAS/FAE or emotional, behavioural or developmental delays. An additional 384 children require formal assessment. Figure 3 shows the number of children diagnosed with a special need by type of need.

FIGURE 3

Number of Children Diagnosed with a Special Need by Type of Need



LEGEND

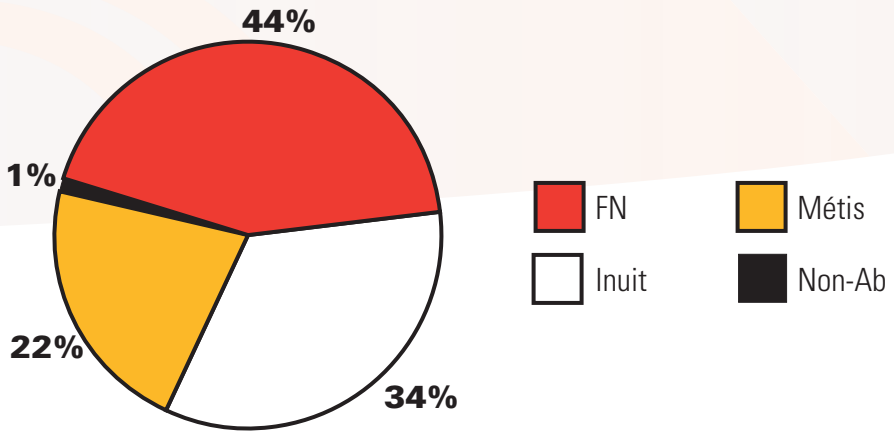
language	=	delays, speech impediments
FAS/FAE	=	Fetal Alcohol Syndrome / Fetal Alcohol Effects
emotional/ behavioural	=	emotional or behavioural problems
developmental	=	developmental challenges or delays
hearing	=	hearing problems
visual	=	visual problems
other	=	traumatic brain injury
physical	=	physically challenged
learning	=	learning disabilities
autism	=	autism

Children and Their Primary Caregivers

Almost half (44%) of the children participating are First Nations, 22 percent are Métis and 34 percent are Inuit. Fifteen percent can speak an Aboriginal language fluently. These children are concentrated in Inuit communities and other remote sites.

FIGURE 4

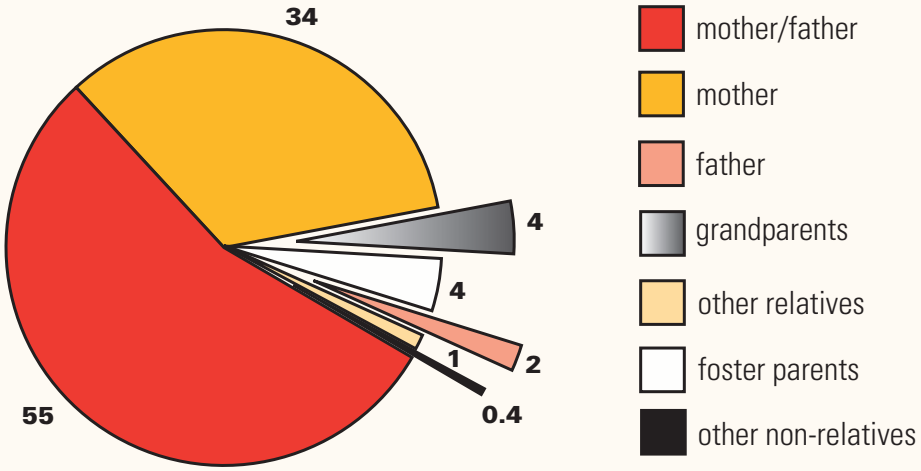
Distribution of Children by Ethnicity



The majority (55%) of all participating children live with both parents, but over a third (34%) live in lone parent homes headed by women. A small group (8%) of AHS participants are being raised by foster or grandparents, and two percent live with their father only.

FIGURE 5

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



In the overall Aboriginal community, less than half (43%) of Aboriginal children under 15 live in a married couple family, 1 quarter live in a common-law couple family, and almost one third (32%) live in a lone-parent family. In larger urban centres, the rates of Aboriginal children living in lone-parent families are higher[1].

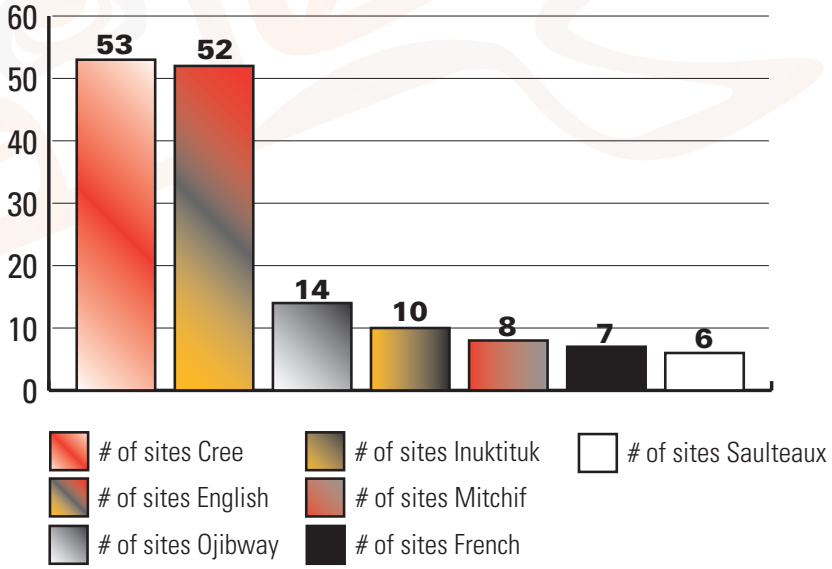
[1] Statistics Canada (1998), The Daily, January 13, 1998: 1996 Census, Aboriginal Data, page 5.

Aboriginal Culture and Language

Most sites report that their primary languages of instruction are English and at least one Aboriginal language. For at least five sites, the primary languages of instruction were French and an Aboriginal language. The most common of the Aboriginal languages taught in class, in ranked order, are Cree (53 sites), Ojibway (14 sites) and Inuktitut (10 sites). Other Aboriginal languages are in use in only one site. The range of languages is great and includes: Algonquin, Atikamek, Blackfoot, Carrier, Chipewyan, Dakota, Dene, Dogrib, Gwichin, Hal'qu'em'elem, Han, InnuEimun, Inuinnagtun, Inuvialuktun, Kaska, Kwa-Kwa-La, Mi'kmaq, Michif, Mohawk, Montagnais, Northern Tutchone, Nuu-Chah-Nulth, Oneida, Saulteaux, Slavey, Smalgyax, and Squamish. In total, thirty Aboriginal languages are used in the presence of the children.

FIGURE 6

Languages Taught in Class



When it comes to more informal language use in front of the children, more sites report using an Aboriginal language. In hierarchical order of frequency, those languages are Cree (47 sites), Ojibway (13 sites), Inuktitut (nine sites), Michif (eight sites), and Saulteax (seven sites). The majority use Aboriginal languages (91%) and books (67%) or toys (71%) reflecting Aboriginal cultures on a daily basis. However, 41 percent report that they never use books in an Aboriginal language. Elders and traditional people are most commonly involved in cultural activities on a daily or weekly basis and parents and caregivers participate in cultural aspects of the program most often on a weekly or monthly basis.

Best practices in the Aboriginal culture and languages component include complete immersion in the language and culture; use of visual aids and culturally appropriate toys, books and resource materials; involving elders, parents and family; use of music and song; and culturally based curricula. Plans for the future focus on increasing elder, parental and community involvement; changes to the curriculum; improved language use; incorporating more music and dance; providing more field trips and training for staff; as well as increasing the use of art, craft and ceremony in class. Change is most commonly measured through observations and feedback in the culture and language component.

Education/School Readiness

The overwhelming majority of projects (80%+) report that daily activities include:

- praising children for their accomplishments;
- listening to music;
- encouraging children to describe their experiences;
- encouraging children to be inquisitive, ask questions and experiment;
- working in groups;
- telling stories;
- promoting letter and alphabet recognition;
- promoting number recognition; and
- familiarizing the children with colours and shapes.

In 54 percent of sites, parents were encouraged, at least monthly, to use teaching materials at home. It was much less common for parents to be encouraged to help with numeracy or literacy lessons, or to take pride in their children's work.

Sites report the most successful strategy for promoting child development and school readiness is a well planned, professionally developed curriculum. Following this, concentrated effort at facilitating child development together with parental and community involvement are also considered important. Regular and effective communication campaigns, an active learning approach, enhancing the child's self confidence, ensuring qualified staff and formally tracking development change are also considered particularly effective. Future plans to enhance impact on school readiness include changes to the curriculum to include more basic academic and cognitive skill development and more exposure to Aboriginal content. Also cited are plans to develop new programs and partnerships; schemes to increase parental and community involvement; increased training opportunities; increased focus on

development and growth; use of more rigorous assessment strategies; and more field trips.

Perhaps more than in any other component of the program, formal assessment is used to measure change with respect to education and school readiness. Some even cite the instruments used, which included the Denver Developmental Screening Test; the Diagnostic Inventory for Screening Children and the Brigance Pre-school Screen for Three and Four Year Old Children. The second most common measurement strategy is observation and, although many report tracking or testing the children, few details of those measurement tools are clear. Finally, feedback in the form of written or verbal comments from parents, staff, community members and kindergarten teachers is the third most common form of measuring impact.

Assessment of a child's needs and progress is seen by Health Canada as crucial when examining program impact. The AHS impact evaluation, on which work is commencing in 2000, will focus on this issue.

Health Promotion

When parents are the target of their health education efforts, most sites distribute information on a monthly basis, although a sizable portion (15%+) give out books, pamphlets or information on health services and child development on a daily basis. When children are the target of their health education efforts, the most popular daily activities are physical activity (79%) and developing motor skills (87%), followed by dental hygiene (59%).

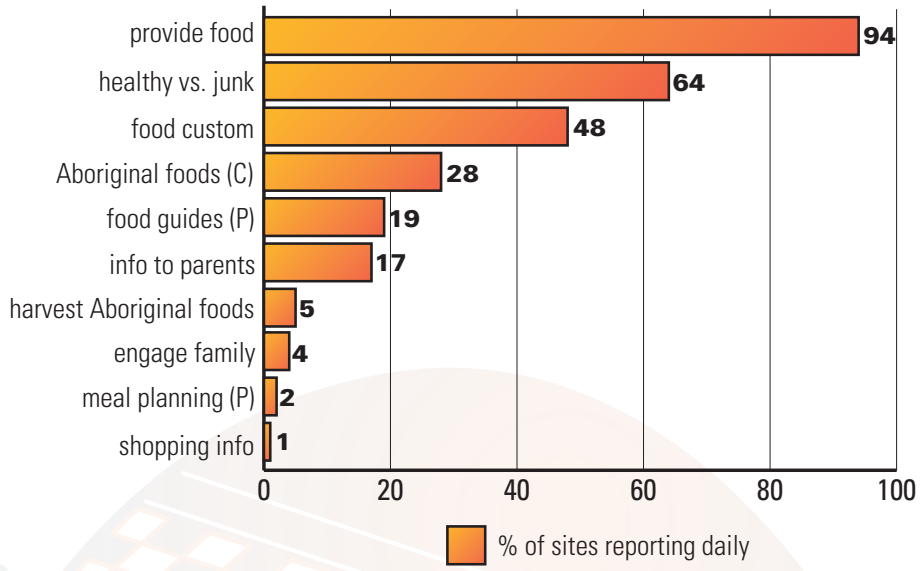
The sites report that the best health-promoting practices (in ranked order) are: health education; hygienic practices; nutrition education; community and professional involvement; hands on activities and parental involvement. Plans for the future include: increasing professional and community involvement, as well as changing the curriculum; organizing training opportunities for parents and staff; increasing parental involvement; and having more field trips. The most common measurement strategy to determine the impact of health-promoting efforts is the observation of changes in the health practices of the children. Feedback and evaluation are also used, although less commonly. Lastly, some use established records like immunization files to determine if they are making any health differences.

Nutrition

Almost every site (94%) provides meals or snacks on a daily basis, and almost half (48%) expose participants on a daily basis to local Aboriginal customs relating to food. While the majority engage families in nutrition-related activities, 30 percent report that this was never done. Parents are most likely to get nutrition-related information (e.g. food guides, workshops, shopping information, meal planning and other general nutrition information) on a monthly or yearly basis. The most common daily lesson for children is aimed at helping them to make the distinction between healthy and junk food. Sixty percent are exposed to Aboriginal foods on a daily or weekly basis, and gathering or preparing Aboriginal food is most commonly a monthly activity.

FIGURE 7

Daily Nutrition Activities by Type



LEGEND

provide food	=	offering a meal or snack as part of the program
healthy vs. junk	=	teaching the differences between healthy versus junk food
food custom	=	exposing the children to Aboriginal food customs
Aboriginal foods (C)	=	exposing the children to Aboriginal foods
food guides (P)	=	exposing the parents to the Canada food guide
info to parents	=	nutrition information provided to parents
harvest Aboriginal foods	=	engaging the children in harvesting Aboriginal foods
engage family	=	engaging the family in nutrition-related activities
meal planning (P)	=	offering information on meal planning to the parents
shopping info	=	offering information on shopping nutritiously to the parents

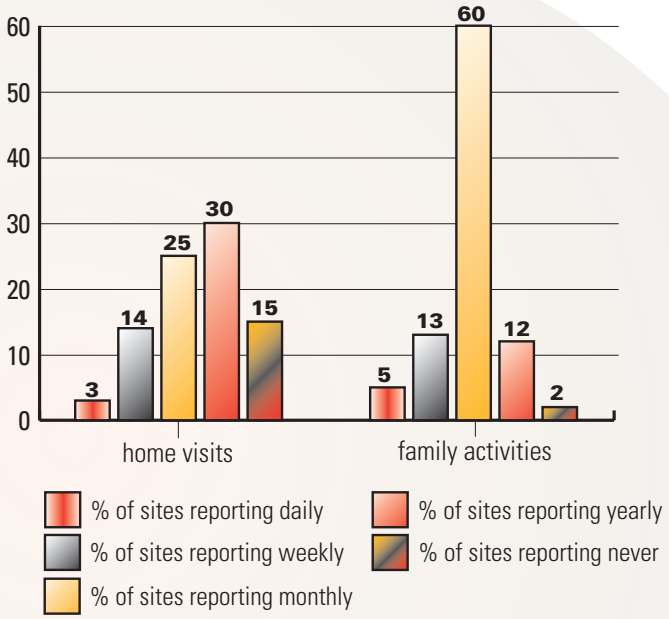
Providing food is considered the best way to teach nutrition. Practical activities and nutrition workshops or training were second and third place best practices. Plans for the future include: generating new ideas for the curriculum; captivating family involvement; offering training sessions and workshops in nutrition; increasing communication; and soliciting greater community contributions. Change is most frequently measured through feedback and observation, although a minority use formal evaluations or indirect measures (e.g. rates of anemia) to assess their impact.

Social Support

Individualized social support for families is offered most frequently through home visits. The purpose of the social support component is to ensure families are made aware of community resources and services and to assist them in accessing these services. Clothing exchanges are available in half of all AHS sites and toy libraries in about a third. Parent self-help groups, family activities and networking opportunities through workshops are most commonly offered on a monthly basis in AHS sites. Parenting skills information is imparted daily in 28 percent of AHS sites, but parents are most likely to receive information on or referrals to social services or a specialist on a monthly basis.

FIGURE 8

***Frequency of Social Support Activities*[2]**



Activities to promote AHS as a community resource are quite common. Almost every site is supported by the local kindergarten class and the public health nurse (96% and 95% respectively). Over three quarters of sites enjoy support from child or day care facilities, family counselors, hospitals or clinics, physicians, dentists, employment training programs, as well as education and literacy programs. Support is weakest with respect to child mental health services and transportation.

[2] NOTE TO READER: When the percent of sites reporting does not equal 100 percent, the difference equals the percentage of sites not reporting.

Forty percent report that they have formal partnerships (established by written agreement) with community agencies, which provides them with significant benefits like access to books, computers, facilities, cultural resources, self-development programs, equipment, budget supplements, lunch programs, teachers, specialists, professional hockey players, prenatal programs and social services, to name a few. Several strong tactics were noted to provide the program and families with social support, including: engaging parents in AHS-sponsored activities; involving the community; offering training to parents; providing family supports; and using "hands on" activities.

Sites plans for the future entail increasing parental involvement; strengthening community commitment to AHS; offering training; and boosting team complements. Change is measured most frequently in the social support component by observation and feedback. For a minority of sites, responses and stories gleaned from parent questionnaires, administrative record keeping on referrals, or the site's linkages to other social service agencies are used as a means of tracking changes in the social support component.

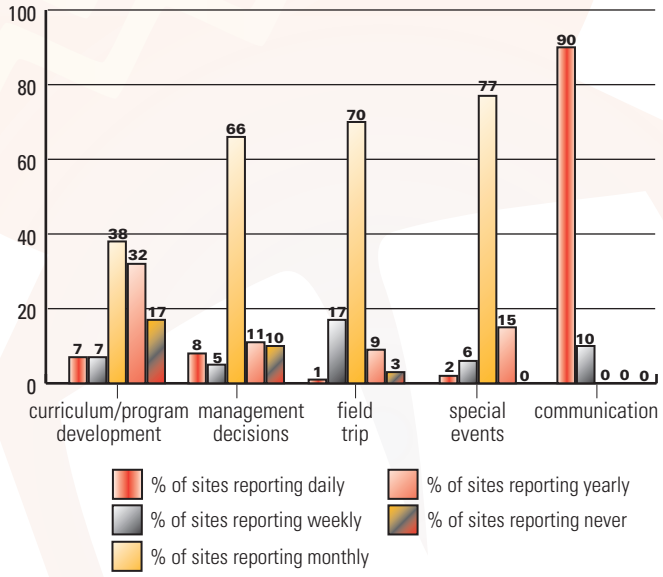
Parental Involvement

Communicating with parents is a daily event for the vast majority of sites (90%), and almost as many (85%) have parent councils that meet an average of 10 times per year. Parents are most commonly involved in management and decision making, field trips, special events and curriculum development on a monthly basis. Just over half (53%) report that parents participate in hiring and evaluation, and most (83%) gave parents a wide variety of decision-making authority. Many (70%) report that getting parents involved has been a struggle, still, the average number of parents participating per site is 14.

The reasons most cited for the difficulty in getting parents involved revolve around conflicting schedules (i.e. between AHS and parent scheduling), as well as parental commitments to work or school. Some cite transportation and personal issues (e.g. lack of interest, motivation), as well as misconceptions about the program, as reasons for parents not becoming involved. One quarter of the sites, however, indicate that they had no difficulty getting parents involved.

FIGURE 9

Frequency of Parental Involvement in various activities



The most common barriers for parents in relation to their child's participation in ranked order, are transportation, scheduling and the limited number of spaces for children in the program. Other barriers cited include: unreliable child care; family issues (e.g. illness, negligence, abuse and poverty); parental fear; and language barriers. AHS teams are most likely to encourage parents to enroll their children by inviting them to the site, holding one on one meetings, and soliciting recommendations from local education and social service professionals. Other strategies include advertising, toy libraries, telephone interviews, home visits, media interviews and open houses. Only 15 percent specifically target fathers in their recruitment methods.

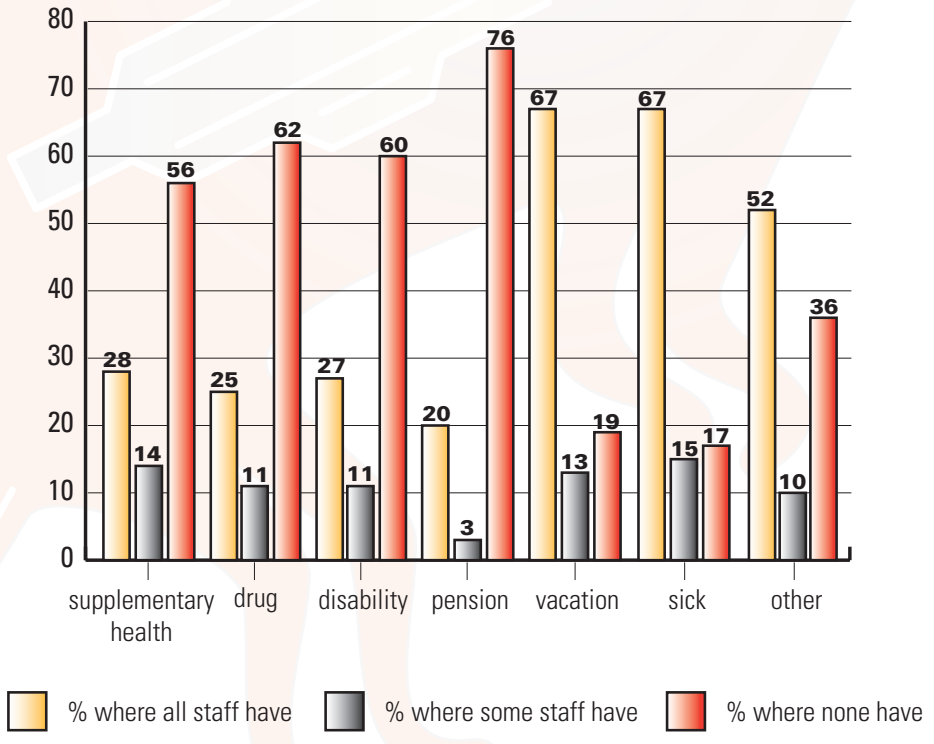
Their best practices to encourage parental involvement, in ranked order of power are outreach, community involvement, hosting training workshops and offering family-support services. Plans for the future include: maintaining a parent focus through outreach and incentive programs; enlisting the participation of the broader community; providing more training; and making curriculum or program changes. Again, impact is most generally measured by observations of and feedback on parental attitudes, behaviors, and levels of comfort and interaction, although some (the minority) have systematically monitored parental involvement.

The Team - Personnel, Training and Volunteers

There are 589 paid personnel, with team sizes averaging about six people. From September of 1998 to May 1999, there was a 33 percent attrition rate. Most team members leave for personal reasons, to pursue other employment opportunities, or for other reasons. Although vacation and sick leave are common benefits, the overall benefits' package for AHS employees is poor. Less than a third of all respondents offer supplementary health, drug or disability insurance. Similar profiles exist for the availability of pension plans. Other benefits that were cited by the majority, however, included things like Canada Pension Plan, unemployment insurance, employee/family assistance plans and savings plans, to name a few.

FIGURE 10

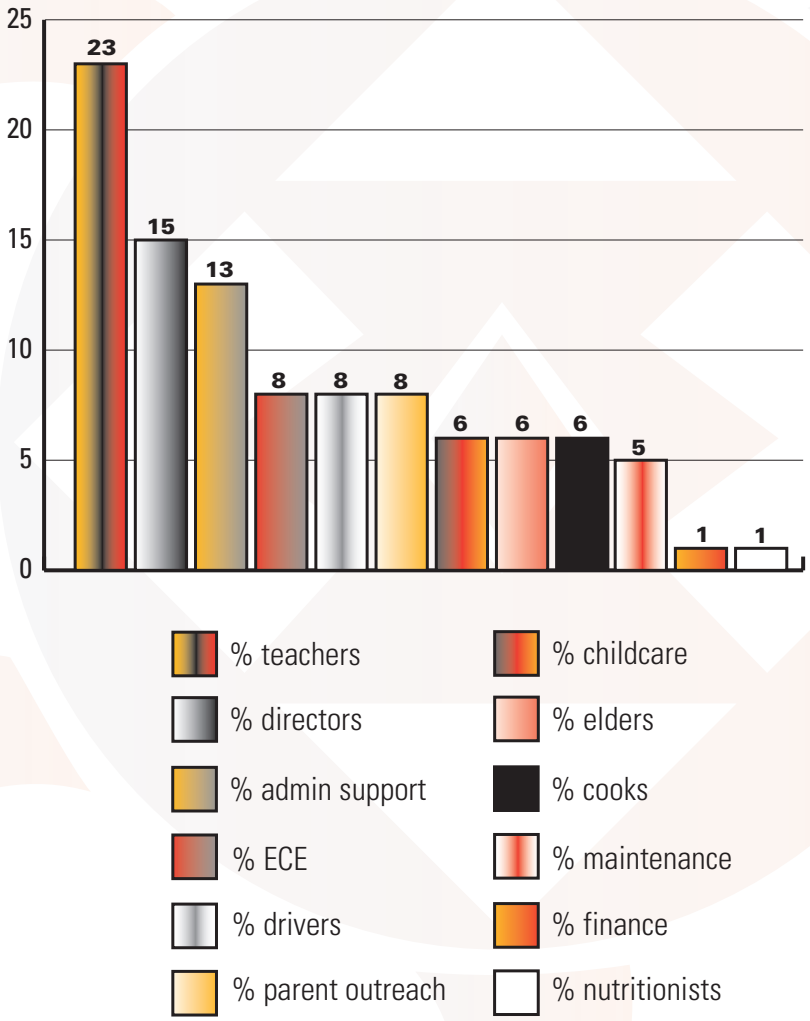
Various Benefits Offered



The distribution of paid personnel by position is shown in Figure 11. The largest segment of the team consists of teachers[3] and directors[4]. Administrative support, parent outreach, bus drivers and those people who are trained in Early Childhood Education (ECE) make up the next most common team categories. Elders, cooks and maintenance crews make up some of the AHS team and, in a handful of situations, nutritionists and finance officers are staff members, too.

FIGURE 11

Distribution of Team Members by Position



[3]"Teacher" would generally include classroom instructors who may or may not have bachelor's degrees in education, or ECE diplomas.

[4]Directors often did not engage in administrative duties alone, but doubled as classroom instructors or curriculum developers.

The majority of the team can be found in the classroom. Administrative support and parent outreach are the next biggest group. Very small proportions (all 6% or under) of the team consist of either elders, cooks, maintenance personnel, finance officers or nutritionists. At least 71 percent of the team is Aboriginal. On average, they work 35 hours a week, at $13.13 an hour, for 44 weeks of the year. Thirty one percent of the team is ECE-trained and 14 percent have either undergraduate or graduate degrees. The most common training opportunities are Health Canada-sponsored (e.g. regional and national training workshops), followed by the opportunity to take courses (43%) as part of the job. Early childhood education training is accessible to the majority (82%); however, when analysed by remoteness, it is clear that ECE training is accessible to virtually all urban projects, but to only 45 percent of remote or Inuit sites. Respondents feel strongly about the need for more professional development training, as well as training to deal effectively with special needs and to facilitate early childhood development. Others feel the need for computer training, and culture and language courses.

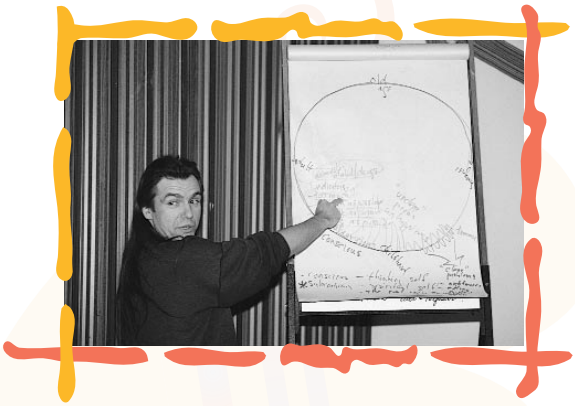
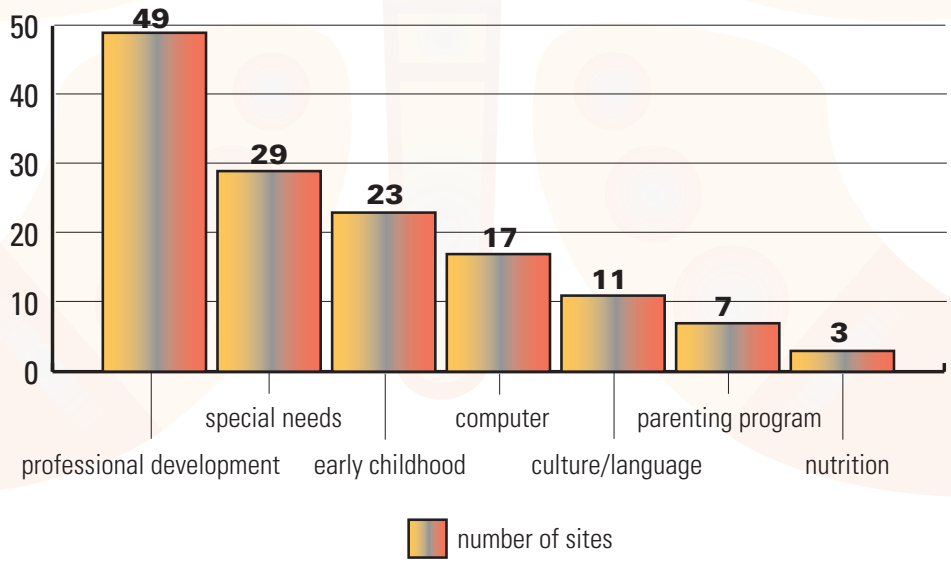


FIGURE 12

Training Needs by Type



In a typical month, over 19,000 service hours in total are contributed by volunteers. If one translates that into dollars and cents using the average hourly wage of $13.13, that means that $249,470.00 are infused into the program each month, or nearly $3 million annually, by volunteer efforts! Family members are most likely to volunteer at special events, probably owing to their commitments to work or school, while community members are most likely to contribute during fund-raising events. Elders that volunteer are most likely to be found in the classroom.

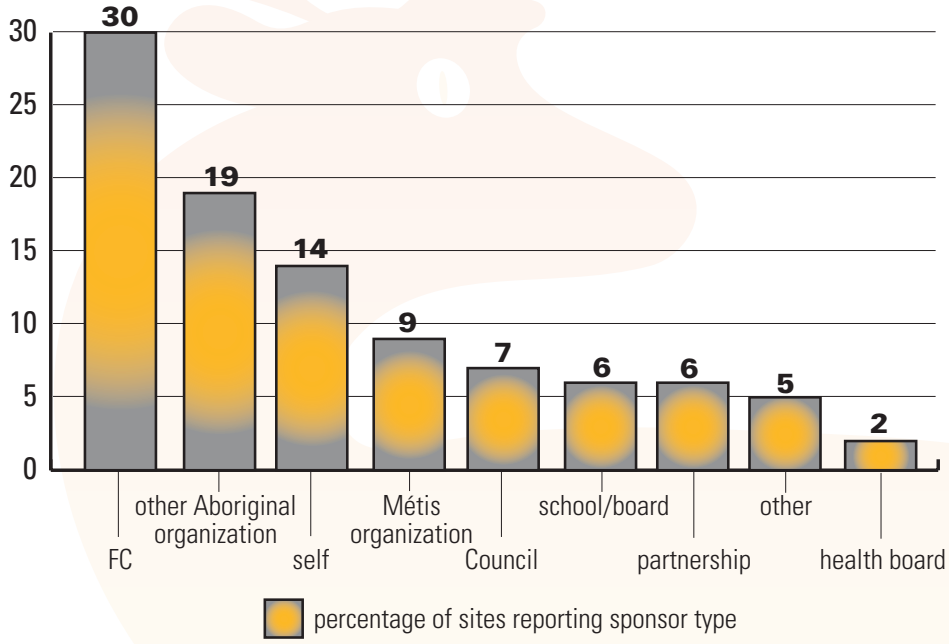
Project Administration and Co-ordination

Friendship centres sponsor almost a third (30%) of all AHS projects in urban centres and northern communities. Nineteen percent are sponsored by other Aboriginal organizations (e.g. health centres, Métis settlements, non-profit organizations), and a sizable group (14%) is self-sponsored; that is, sponsored by an incorporated group of parents. About a quarter of all sites share a sponsor or transportation services, half share space or equipment, and about a third share staff. Their partners are many and varied, but most commonly include school boards, other early intervention programs, health centres, the Community Action Program for Children and child care centres.

Projects rated the program highly in relation to a number of its key features. Most projects feel good about overall program design, development and national management. Regional program consultants and regional management are very highly regarded. The majority (81%) of projects rate the regional and local evaluation processes as good or better. Least favoured among administrative processes, however, are funding renewal, cash flow and national evaluation processes.

FIGURE 13

Sponsor Types



LEGEND

FC	=	Friendship Centre
Other Aboriginal organization	=	Other Aboriginal organization
Métis organization	=	Métis organization
Council	=	Band Council
Self	=	Self-sponsored
School/Board	=	school or education board
Partnership	=	any combination of sponsors
Health Board	=	health board
Other	=	non-profit organizations, Métis settlements

Participant Challenges

Just over a quarter (26 percent) of AHS sites see parental involvement as their most serious challenge in relation to participation. This is consistent with findings from the Head Start program in the United States, where parental involvement has been a continuing challenge throughout the nearly forty years of its history. Twenty percent of sites perceive low literacy skills among parents as a serious challenge to parental involvement, and 14 percent of sites believe that FAS/FAE among parents is a serious problem. Almost half of AHS sites experience challenges associated with teen parenting: for some (9%), it is serious, but, for others (40%), it is seen as a minor problem. Special needs support for speech problems are the most common, serious challenges related to the children, followed by behavioural problems.

Teams feel professional development training was the best way to deal with family challenges, followed by encouraging parental involvement and drawing on the support of community resources. Their plans for the future feature training most prominently; then, creative strategies to solicit parental involvement such as providing greater incentives, increasing parental decision-making authority; or expanding staff complements to include an outreach worker. Increased program sensitivity and adaptability to special needs was also mentioned, as was greater inter-agency support and fine tuning program administration.

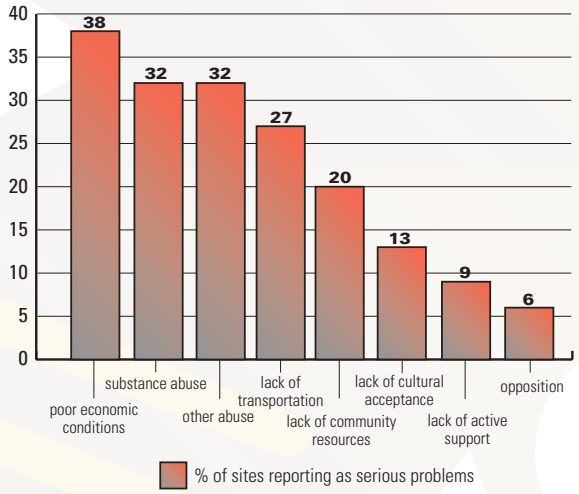
Although little is known about rates of chronic or infectious disease, and traumatic injury, in the AHS group, it is known that ear problems (15%), allergies (13%), asthma (12%) and bronchitis (7%) were prevalent in the sample of Aboriginal people in Canada responding to the First Nations and Inuit Regional Health Survey (FNIRHS), which profiled First Nations and Inuit children ages 0-11. In the national sample, seven percent were overweight or had psychological problems. Similarly, the Canadian Institute for Child Health reports that First Nations infants are four times more likely to die of injury than other Canadian infants. For toddlers and pre-schoolers, the rate is more than five times greater: 15/100,000 for other Canadian pre-schoolers and 83/100,000 for First Nations pre-schoolers! Non-fatal injuries in the 0-5 age group were, most commonly, broken bones (4%), serious burns (3%) and serious head injuries (3%). Behavioural or emotional problems were noted for nine percent of the young group (0-5yrs).

Community Challenges

The greatest community challenges faced by projects are poor local economic conditions, identified by 38 percent of sites, and substance abuse and other forms of abuse - such as family violence - identified as serious challenges by almost a third of sites. More than a quarter (27%) of sites find the lack of transportation a serious problem, and one-fifth cite a lack of community resources and services. For some sites (13%), a lack of acceptance of Aboriginal children's cultural difference by the school system and a lack of active support from the community (nine percent of sites) are serious issues.

FIGURE 14

Community Challenges



LEGEND

poor economic conditions = poor economic conditions
substance abuse = alcohol, drugs and solvents
other abuse = family violence and other
lack of cultural acceptance = lack of acceptance of Aboriginal cultural differences at local schools
lack of active support = lack of active support from the local community
opposition = opposition to the program from local community

By comparison, it is interesting to note that 8.5 percent of First Nations people living off reserve, 7.5 percent of Métis and 12.7 percent of Inuit families reported food shortages. For the Canadian population overall, it is estimated that 7.5 percent report food shortages as a problem. When we look at employment, 24.5% of Aboriginal people were unemployed in 1996, as compared to a ten percent unemployment rate for Canadians generally[5]. When questioned about their perception of community challenges, Aboriginal people (First Nations off-reserve, Métis and Inuit) cited unemployment, substance abuse, family violence, sexual abuse and suicide as social problems[6].

To overcome community challenges, AHS teams feel that their single most potent strategy is to establish partnerships and enlist community participation. Other effective means of dealing with challenges are to invest in parents through training and workshops; use cultural activities and festivities as a way of celebrating the positive; engage in effective communication; and ensure strong program design. Plans to improve their ability to master their environments include improving public relations, providing transportation, increasing fund-raising activities, parental involvement and cultural content, and, last, but not least, ensuring qualified staff or providing training.

[5]Caledon Institute of Social Policy, (1999), *Aboriginal People in Canada's Labour Market,* page 9.

[6]Adapted from Statistics Canada, *Language, Tradition, Health, Lifestyle and Social Issues,* 1991 Aboriginal Peoples Survey, 1993 as cited in Canadian Institute for Child Health: *The Health of Canada's Children:* A CICH Profile, 1994, page 140.

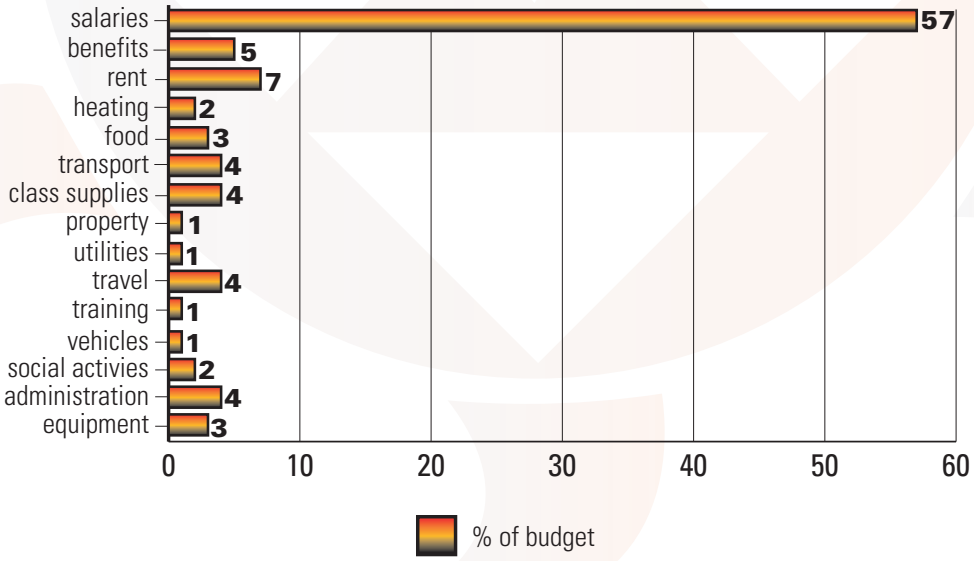
Program Finances

Median Health Canada funds received by all AHS sites for the period April 1, 1998 to March 31, 1999 were $200,000. Median expenditures by sites were slightly higher, at $200,268. In specific kinds of sites, the picture is very different: in Inuit sites, median Health Canada funding is $177,000, while median expenditures are $240,000. In all remote sites, median funding is $124,000, while expenditures are $170,000. The difference is accounted for by funding and donations from other sources, as described later. It is only in urban sites that the Health Canada funding precisely matches expenditures, at $212,000.

The biggest single cost for all sites is salaries. Sites spend a median amount of $123,155 annually; the exception to this is remote sites, which spend a median amount of $96,918. Staff benefits cost sites a median amount of $10,000, with wide variation depending on the type of site: $21,416 in Inuit sites, versus a median amount of $6,253 in remote sites. As discussed in the section on sites' teams (page 19), this can be accounted for by the broad range in the extent of benefits that sites are providing to their employees, with the typical benefits package being inadequate.

FIGURE 15

Cost Categories as a Percent of Total AHS Budgets



AHS sites spend roughly comparable amounts of money for rent of facilities to house their projects. Median rental costs for all sites are $14,700 annually. Inuit and urban sites spend slightly more than this, at $15,200 and $15,805 respectively; sites in remote communities spend slightly less, at $10,017. The 1999 survey from which these data comes did not ask sites about mortgage expenses in those sites that own their own building; this question was added to the 2000 survey.

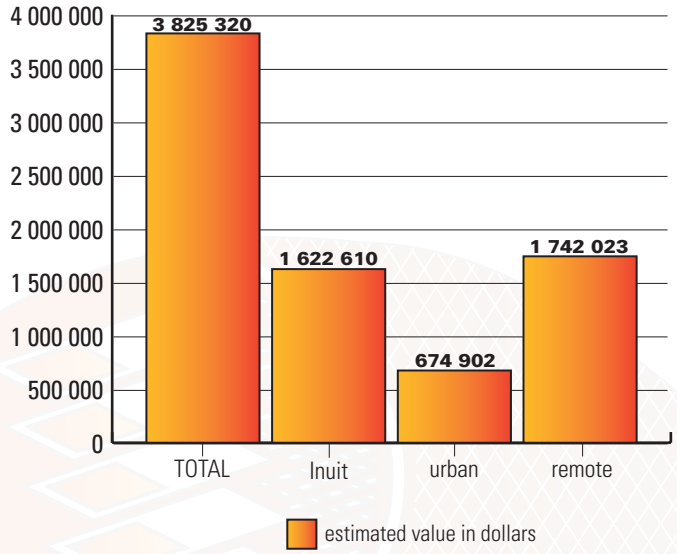
Many other costs were identified by sites, such as bank fees; property expenses (e.g. insurance, renovations, waste removal); travel (to participate in meetings, training or field trips); training; vehicle expenses (because many sites own and operate buses or minivans); administration (e.g. audits, honoraria for elders, professional fees, insurance, advertising); and equipment/supplies (e.g. books, toys, furniture, office and cleaning products). To highlight two of these: sites spend a median amount of $4,130 on training, but the median amount for Inuit sites is significantly higher than this, at $14,665; and sites spend a median amount of $7,300 on equipment and supplies, with Inuit sites again higher, at $12,500. These two categories of spending are crucial to the maintenance of a quality program: trained staff has been demonstrated by a number of studies to be a significant factor in maintaining or improving early childhood education quality, and classrooms must be adequately supplied with learning resources for children, and safe play equipment, to have a quality program.

As mentioned earlier, total expenditures of AHS sites consistently exceed Health Canada funding ($19,045,000 in direct support to urban and northern projects in 1998-99). In order to supplement Health Canada funding, AHS sites have proven to be skilled at fundraising from other sources, including municipal and provincial governments, other federal programs, private granting foundations, Aboriginal organizations and community donations. More than three million dollars in additional funding was raised from all of these sources in 1998-99!

When examining the estimated total value of donated goods and services, it is clear that an additional $766,693 comes into the program in the form of labour, space, food, transportation and classroom material. This time, urban projects are the prime beneficiaries. Taken together, the total value of donated funds and contributions of goods and services injected $3,825,320 in AHS in fiscal year 98/99. When broken down by Inuit, urban and remote sites, it is clear that Inuit and remote sites are at a greater advantage than their urban counterparts, when it comes to the total amount of donated resources.

FIGURE 16

Breakdown of Total Amount of Donated Funds, and Goods and Services 98/99 (Inuit, Urban/Remote)



Program Needs and Desires

Despite projects' successes in raising funds from a variety of sources, there is an almost ***unanimous call for increased funding***[7] to:

- boost staff complements and benefits;
- contribute to program development and expansion;
- provide training;
- improve and expand facilities;
- offer transportation;
- develop/distribute culture and language resources;
- purchase equipment and supplies;
- secure resources for special needs;
- solicit and establish partnerships/networks;
- improve communication, obtain professional assessments and encourage paternal involvement; and
- organize family support and improve administrative services.

The needs identified by AHS urban and northern sites show that they have a strong desire to improve their programming. With ongoing funding even at the same level, Health Canada can work with projects to help make quality improvements in areas such as services to special needs children; parental involvement; curriculum resources; and training for staff and parents. Health Canada has already put some focus on the issue of special needs children in Aboriginal Head Start through a special report produced in 1998. Parental involvement is a priority in training events and Health Canada support to local projects. Health Canada provides assistance and resources to sites to expand the range of curriculum materials that are available. Training is supported by Health Canada through regional training events, annual national training workshops, and training of AHS teachers in the High/Scope Perry Preschool methodology. Finally, AHS sites can and do seek out resources from other levels of government and funding sources to enhance the vital work that they are doing at the community level.

While participants have made it clear that additional funding is highly desirable, the evidence from the 1998-99 administrative survey also demonstrates that the program has achieved a number of its key goals. Aboriginal Head Start's mission statement says that the program *"will provide comprehensive experiences for First Nations, Métis and Inuit children up to six years of age and their families, with primary*

[7]Whenever qualitative answers are listed without clear ranking of their priority or frequency, the first item was the most commonly cited, the second is the next most frequently cited, and so on.

emphasis on preschoolers, 3-5 years of age," with the program to be based on traditional community beliefs within a holistic and safe environment. It is clear from the administrative survey results that AHS sites have succeeded in providing comprehensive experiences to preschool children and their families, with programming taking place in all sites, in all of the six AHS component areas: culture and language; education; health promotion; nutrition; social support; and parental involvement. Within a five-year period, the program has established a network of early childhood development centres for Aboriginal people, where none previously existed. Prior to 1995, no Aboriginal child had the opportunity to participate in a national early childhood program specifically designed to meet her needs; in 1999, 3,200 children in urban and northern communities did.

The program's mission statement goes on to state that "*the primary goal of this initiative is to demonstrate that locally controlled and designed early intervention strategies can provide Aboriginal preschool children in urban and northern settings with a positive sense of themselves, a desire for learning, and opportunities to develop fully and successfully as young people.*" Demonstrating that the program has achieved this goal is the role of the national impact evaluation, to commence in 2000-2001. The evidence supplied by the survey reported on here indicates that Aboriginal Head Start, through its range of activities, its group of dedicated staff and community supporters, its ability to work collaboratively with other programs and services, has ample potential to achieve that goal.