Early Childhood Development - models and studies

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Education Renewal Initiative Secretariat
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The Government of Canada announces early childhood development initiative for Aboriginal children

ONEIDA NATION OF THE THAMES, ONTARIO - The Honourable Ethel Blondin-Andrew, Secretary of State (Children and Youth) today announced, on behalf of the Honourable Anne McLellan, Minister of Health, the Honourable Jane Stewart, Minister of Human Resources Development Canada, and the Honourable Robert D. Nault, Minister of Indian Affairs and Northern Development, a funding allocation of $320 million over the next five years for a strategy to improve and expand Early Childhood Development (ECD) programs and services for First Nations and other Aboriginal children. This strategy complements the Federal, Provincial and Territorial ECD Agreement announced by First Ministers in September 2000.

Today's announcement is a new investment to expand the Aboriginal Head Start Program for Aboriginal children living on and off reserve and to enhance and expand the First Nations and Inuit Child Care program. Through the federal strategy, the Government of Canada will take additional measures to address the gap in life chances between Aboriginal and non-Aboriginal children. The investment also enables the Government of Canada to intensify its efforts to address Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) in First Nations on reserve. Funds will also support a national survey on Aboriginal children and research at the community level.

"Providing Aboriginal children with a good start in life is essential for their health and successful development," said Ms. Blondin-Andrew. "The Government of Canada will continue to work with Aboriginal organizations, provinces and territories and key stakeholders to ensure that every Aboriginal child has an opportunity to realize his or her full potential."

Ms. Blondin-Andrew made the announcement while visiting the Oneida Nation of the Thames, a First Nations community in Southwestern Ontario. She was joined at the event by members of the Oneida community.

The federal strategy will be implemented by Health Canada, Human Resources Development Canada and Indian Affairs and Northern Development in consultation with Aboriginal organizations and communities. It will:

- improve and expand existing ECD programs and services for Aboriginal children, with a particular focus on programming for First Nations children on reserve;
- work towards the development of a "single window" approach to ensure better integration and coordination; and,
- introduce new research initiatives to improve understanding of how Aboriginal children are doing, and what can be done to ensure their healthy development.

Funding for this project was provided for in the December 2001 budget and is therefore built into the existing fiscal framework.

Determinants of Health Influencing Aboriginal Children - excerpts

- Population
- Income and Social Status
- Education
- Social Environment
- Health Services and Social Services
- Culture

Population

The Aboriginal population (all ages) for Canada is 799,010. Of that figure 529,035 are First Nations citizens, 204,120 are Métis, 40,220 are Inuit and 25,635 are others.[1] In 1996, about 45% of the total Aboriginal population lived in one of the three Prairie provinces.[2] The proportion of Aboriginal people to overall population is significantly greater in Saskatchewan and Manitoba (11.4% and 11.7% respectively).[3]

- The population of First Nation children aged 0 - 14 equals 80,420 or 35% compared to the general Canadian population aged 0 - 14 of 5,899,200 or 20.7%.[4]

- The Aboriginal population of youth aged 15-24 totals 143,790 or 18% compared to the general Canadian youth population aged 15-24 which is 3,849,025 or 13.5% The population of Aboriginal youth is growing more quickly (about 1.4 times faster) than the non-Aboriginal youth population and is expected to grow at that rate through the 1996-2011 period.[5]

- High rates of Aboriginal population growth are projected to occur throughout the next 20-year period. Growth during the 1996-2011 period is expected to occur at a rate of 1.8 percent annually, about 1.7 times faster than the Canadian rate.[6]

- The First Nations population continues to display a "youthful" age structure. In 1996 the average age of the First Nation population was about 25.5 years, approximately 10 years younger than the non-First Nation population.[7]

- In 1996, there were 491 children under the age of 5 for every 1,000 Aboriginal women of childbearing age. There were 290 children under the age of 5 for every 1,000 women of childbearing age in the general population.[8]

- In 1991, in the Northwest Territories, where Aboriginals make up 62% of the population, 74% of children from birth to age 15 years were Aboriginal.[9]

- In Manitoba, recent analyses of historical trends based on Indian Register data have indicated average national fertility rates for First Nations women have declined from 5.7 births in 1970 to 4.1 in 1975, to 3.4 in 1980, to 3.2 in 1985, to 2.7 in 1990 and 2.55 in 1995. The fertility rate for Status Indians, however, remains higher than for the general population (at 1.8 births per woman) and the decline in the fertility rate has been more than offset by increases in the numbers of women in their young child bearing years. This has resulted in a birth rate which has stabilized at a level almost twice that of the mainstream population. The large numbers of young children, ageing into their reproductive years, guarantees that Aboriginal birth rates will remain extremely high in Manitoba for several decades to come, regardless of declining fertility rates.[10]

- The three Prairie provinces have the highest fertility rates for First Nations women in the country. In 1990, when the national average rate was 2.72 births per woman, the Manitoba rate was 3.01, the Alberta rate 3.05 and the Saskatchewan rate 3.49. The lowest First Nations fertility rates were found in Ontario (2.33) and B.C. (2.24). This combined with a generally younger age profile means that birth rates in the Prairies for Status Indians will remain well over the national average, and that the Prairie Provinces' share of the total national First Nations population will continue to increase. On the other hand, the increase in the total Aboriginal population will be slowed by the lower birth rate among the Métis, who are also concentrated in the Prairie provinces.[11]

- The Inuit population is undergoing rapid growth. This is a function of both the population's youthfulness (39% under at or under 14 years of age in 1991) and of Inuit women's high fertility rate, which is more than double that of the general Canadian female population.[12] Inuit women tend to become pregnant at an earlier age and have larger families than either First Nations or non-Aboriginal women.[13]

- Nunavut's population is very young. In 1998 there were an estimated 3,627 children aged 0 - 4 and approximately 3,838 adults aged 45 years or more.[14] Children under the age of 10 accounted for a greater proportion of Nunavut's population than children aged 10 to 19 years. Children and youth (birth to 19) accounted for approximately 46% of Nunavut's population. With almost half of its population under the age of 20, Nunavut has particular challenges to meet in areas of health care, health promotion, education, recreation and youth employment.[15]

- There has been an increase in the proportion of the First Nations population living off-reserve. By 1997, 42% of Registered Indians lived off-reserve compared to 29% in 1982. Part of this increase is attributable to Bill C-31, through which many names were added to the Indian Registry.[16]

Income and Social Status

An adequate income contributes positively to a child's physical and mental health, cognitive and social development and academic achievement — benefits that will serve them well for the rest of their lives.

Children who grow up in poverty have a greater risk of health problems, disability and death. They are more likely to drop out of school, have emotional problems, and mental health disorders, get in trouble with the law, engage in risk-taking behaviour and die as a result of injuries. Poverty is recognized as the single most significant determinant of a child's level of health. A commitment to the healthy development of children in Canada requires a commitment to raising family incomes and socio-economic status.

Aboriginal poverty is compounded by the multiple social and health risk factors that are the legacy of colonization. The distinct nature of Aboriginal child and family poverty in Canada is rooted in multi-generational experiences of residential schools, wardship through the child welfare system, and economic and social marginalization from mainstream Canadian society. For generations, the mere fact of growing up Aboriginal meant growing up poor. And as Aboriginal families now struggle to regain parenting and life skills that were displaced by the residential school system and other state interventions, many are doing so under the burden of poverty. These oppressions fuel the widespread addictions and family and community violence that Aboriginal communities must grapple with today.

The rate of Aboriginal children living in low-income families is more than twice the national rate. Earned income per employed Aboriginal person in 1991 was $14,561 compared to $24,001 for the general Canadian population.[17] Poverty has a significant and long-lasting effect on children's health outcomes. Many problems including iron deficiency, poor oral health and *otitis media* have been closely linked with low income and lack of formal education. This correlation is significant precisely because poverty is so widespread, particularly among Inuit families with well over half of Inuit women reporting an annual income in 1991 of less than $10,000.[18]

Education

Education is an important determinant of health, closely associated with employment and income. Education provides children with one of the best chances they have to improve their economic security, job satisfaction, quality of life and ability to enjoy a healthy lifestyle. The trend towards a knowledge-based economy has had an influence on the need for higher education. Without this higher education, the future success of the young is compromised.

- In 1996, 54% of Aboriginals over the age of 15 did not have a high school diploma. (In the non-Aboriginal population, the percentage is 35%.)[19]

- The percentage of Registered Indian children and youth remaining in school for 12 consecutive years of schooling rose sharply between 1987-88 and 1993-94, from 37% to 78%. The figure fell somewhat to 71% in 1996-97.[20]

- With respect to women, the relationships between educational attainment and single mother status are different for different Aboriginal identity and age groups. Among young Métis women, and among young non-Aboriginal women, the proportion of single mothers decreases as education increases. Among young Inuit women, the proportion of single mothers increases as education increases. The relationships between educational attainment, age and the prevalence of single mothers is less clear among Aboriginal women than among other Canadian women.[21]

Social Environment

Continuing evidence of racism and institutionalized discrimination against Aboriginal peoples in Canada spills over to First Nations children and youth, who end up experiencing significant difficulties at home and at school.[22]

Parents need a supportive environment in which to raise their children, an environment that fosters their knowledge and growth as caring parents and that recognizes and helps them cope with the stresses of raising children. School and community networks provide the support and enrichment needed to create safe and nurturing environments. Children who have had the opportunity to participate in a wide variety of activities and programs outside the family are more likely to view themselves as capable human beings.

Family structure influences the level of support available to both parents and children. Shrinking and changing families put an increased focus on school and community networks to provide developmental opportunities through informal play, organized recreation, schooling and cultural experiences.

- The majority of Aboriginal children live in two-parent households. According to the 1996 census, approximately two in three Aboriginal children under the age of 15 years lived in a two-parent household.[23]

- The 1996 census found that approximately 57% of First Nations youth resided in two parent households, 25% lived in lone parent households and 18% lived in non-family settings. Compared to non-Aboriginal counterparts, First Nations youth are 1.6 times more likely to report living in a lone-parent family and about 1.4 times more likely to report living in a non-family setting.[24]

In 1996, twenty-three per cent of registered Indian families were female lone parent families; 16% of other Aboriginal families were female lone parent families and 12% of other Canadian families were female lone parent families. Differences between Registered Indians and other Canadians in the proportion of female single parent families are greatest in urban areas and smallest in rural, off-reserve areas. The proportion of female lone parent families increased from 20% in 1991 to 23% in 1996; Among other Canadian families the proportion increased from 9% to 12%.[25]

- In 1996, 32% of Aboriginal children under the age of 15 lived in a single-parent family. This is twice the rate of the general Canadian population. Lone-parent families had average incomes that were ½ those of all families in 1995.[26]

- In 1996, Aboriginal youth were 3 times more likely to be a lone parent and about 2.5 times more likely to live with a common-law partner than non-Aboriginal youth.[27]

- Inuit children and youth are more likely than their non-Aboriginal counterparts to grow up in a family headed by a teenager or lone parent. In Nunavik, for example, nearly one-quarter of households are led by a single parent.[28]

- In 1996, more than 10% of Aboriginal children (age 0-14) were not living with their parents. That is 7 times more than compared to non-Aboriginal children. Apprehension by child and family services represents one of the most common reasons. Four per cent of First Nations children were in the care of Child and Family Service agencies in 1996/97.[29]

- In 1996-97, 3.6% of Registered Indian children were in the care of Child and Family Services agencies.[30] It has been estimated that Indian children are taken into foster care at well over 4 times the rate of non-Aboriginal children.[31]

- Nearly one-quarter (23%) of the Nunavik population aged 15 years or older has been adopted.[32]

- A lower proportion of urban Aboriginal youth live with their parents — just over 50% — compared to 60 % of all urban youth, and a higher proportion of urban Aboriginal youth live with a spouse or as a single parent — 25 per cent compared to 13 per cent of all youth. Like other urban youth, less than five per cent of urban Aboriginal youth live alone.[33]

The degree of violence and fear in children's lives has a significant influence on their health and well-being. Children are put at risk when they witness violence or are direct victims of abuse. Combined with the values and norms of the broader society as a whole, the feeling and experience of security and support can have a profound impact on the physical, mental, spiritual, social and economic health and well-being of children.

Living with violence or the fear of violence has a devastating long-term impact on children and on society. Children and adolescents with histories of maltreatment are more likely to engage in risky behaviours and to come into contact with the justice system. Adolescents who have experienced neglect, physical, emotional or sexual abuse, or exposure to inter-parental violence are more likely to run away from home and to use tobacco or other drugs. They are often less able to adjust to life changes and are more likely to contemplate suicide, suffer from mental illness and engage in criminal behaviour.

- It has been estimated that at least three-quarters of Aboriginal women have been the victims of family violence and up to 40% of children in some northern native communities have been physically abused by a family member. In contrast, children in the general Canadian population represented less than one-quarter of victims of physical assaults or of all violent crimes reported to a sample of 154 police departments in 1996.[34]

School and community-based programs that offer information and support for parenting skills, child development, early intervention, violence prevention, conflict resolution and social skills development are becoming more important in ensuring a healthy social environment for children and their families.

- Child care services are regarded by Aboriginal groups as a necessary support to employment and education opportunities. Aboriginal child care is also seen as an important component of the process of healing under way in many Aboriginal communities. Child care centres are envisaged as vehicles of cultural affirmation and transmission.[35]

- Aboriginal Head Start empowers parents and their communities to meet the development needs of young children. The target group is Aboriginal children 0-6 with a primary focus on children 3-5 years old and their families. All projects focus on six program components: culture and language, education, health promotion, nutrition, social support and parental involvement. Ninety-four percent of programs provide daily meals as part of the nutrition component. 112 Aboriginal Head Start sites in 8 provinces and 3 territories enrolled approximately 3,500 children in off-reserve preschool programs in the 1999-2000 term. There are over 27,000 3 and 4 year olds living off reserve and over 600 children are on waiting lists.[36]

- Aboriginal Head Start is in the process of being expanded to reserve-based communities. Proposal review is still underway. As of January 2000, 173 proposals have been approved across Canada (36 for needs assessment development, 137 for ongoing operational projects).[37]

- The Child Development Initiative of the Brighter Futures Program is designed to assist First Nations and Inuit communities in developing community-based mental health and child development programs. These programs include activities in areas such as healthy babies, parenting skills, childhood injury prevention, community mental health and solvent abuse. Fifty million dollars was distributed by regional offices to all First Nations and Inuit communities across Canada, allowing for maximum flexibility at the community level.[38]

- Canadian Prenatal Nutrition Program (CPNP) is a comprehensive program designed to provide food and/or vitamin mineral supplements, specialized counselling on personal health issues, infant development, breast-feeding and proper nutrition/diet. Projects work with participants to modify unhealthy and high-risk behaviours such as smoking and alcohol use and raise awareness of the lifelong health effects of FAS/FAE. As of June 2000, there were 400 projects in Aboriginal communities serving 6000 women.[39]

- FAS/FAE programs. In the 1999 budget, $3.8 million over 3 years was allocated to FAS/FAE programs.[40]

- The Community Action Program for Children (CAPC) funds community-based projects that support the healthy development of children, directly or through services for parents and caregivers. In 1999, 39 CAPC projects serving Aboriginal families were sponsored by Aboriginal organizations and 6 CAPC projects serving Aboriginal families were significantly governed by Aboriginal organizations.[41]

Health Services and Social Services

Throughout childhood, there are opportunities to provide the conditions and supports that keep children on healthy developmental pathways. Health and social services are essential to promoting this positive development. If opportunities are missed, or if children are disadvantaged in some way, services can help reduce the risk of negative consequences, and in many instances ameliorate those that do occur. Having a continuum of services and supports ranging from promotion and prevention at one end, to treatment and long-term care at the other, allows health and social services to contribute to healthy child development at all points of well-being.

Culture

Although it is often overlooked, culture is an important determinant of health. It refers to a shared identity, based on such factors as common language, shared values and attitudes, and similarities in ideology. Aboriginal people face additional health risks due to marginalization, stigmatization and lack of access to culturally appropriate services. Culture-specific practices can also have an impact on the overall health of a population.

- A 1998 study has found a strong inverse relationship between the level of cultural continuity in a community and the youth suicide rate. The six protective cultural factors they measured are self-governance, land claims negotiation, cultural facilities (as defined by the band) and local control over education, health services and police/fire services. The presence of three or more factors in the community was associated with a substantial decrease in the youth suicide rate.[42]

- cultural and community health. In the last century or so, ten Aboriginal languages have become extinct and at least a dozen are on the brink of extinction. As of 1996, only 3 out of Canada's 50 Aboriginal languages could be considered secure from the threat of extinction in the long run. Use of an Aboriginal language varies with age and geographic locale.[43]

- About 1 in 5 Aboriginal youth reported an Aboriginal mother tongue in 1996, a rate about 2.5 times lower than that of their grandparent's generation.[44]

- Only 15% of Aboriginal youth reported use of an Aboriginal language in the home.[45]

Aboriginal Health Outcomes for Children

Researchers are increasingly focusing upon the effects of the environment and life experiences in the early childhood years on long-term life outcomes. Social conditions and how children are cared for in the early years influences problem solving, language acquisition, coping skills and productivity for the rest of their lives.

Of particular interest are the risk factors responsible for negative outcomes and how these factors interact. What is important to note is that children with multiple risk factors show significantly more negative outcomes than children with fewer risk factors present. The effect is multiplicative, not additive. Research shows that when children show only one risk factor, their outcomes are no worse than those of children showing none of the identified risk factors. But when children have two or more risk factors, they are four times as likely to develop negative outcomes, including social and academic problems.[46]

Health Outcomes, ages 0 - 6

Birth rate

- The Registered Indian birth rate has been consistently higher than the national birth rate in Canada. In 1993, the Registered Indian birth rate was 28/1,000 population compared to the national rate of 13/1,000.[47]

Infant Mortality

- In 1994, the infant mortality rate of the First Nations population was 12 deaths per 1,000 live births. In 1996, the non-Aboriginal population's infant mortality rate was 5.6 deaths per 1,000 live births.[48] As for trends, the Registered Indian mortality rate fell steadily during the last twenty years until, in 1993, it approximated the 1979 national infant death rate. Between 1993 and 1996, the infant mortality rate or the Registered Indian population rose slightly.[49] Data from Eastern and Central Canada, the Prairies and British Columbia indicate that from 1995 to 1997, the infant mortality rate in First Nations was up to 3.5 times higher than the 1996 national rate.[50] Indian and Northern Affairs has estimated the infant mortality rate at roughly twice the Canadian average.[51]

Neonatal and Post-neonatal health

- Dramatic improvements have been made in Aboriginal neonatal health, such that the difference between the national and Aboriginal death rate is less significant. This can be attributed, in part, to improved prenatal and postnatal care and services and, in part, to improved maternal health and health behaviours. In 1997, the neonatal death rate was up to 2 times higher, while the post-neonatal (age 29 days to one year) mortality rate was up to almost five times higher in First Nations than in the general Canadian population in 1995.[52] Since 1979-81, the mortality rate for the post-neonatal period has declined in the Aboriginal and national populations. In 1979-81 and in 1991-93, the Aboriginal post-neonatal morality rate was roughly 3.5 times that of the national population.[53]

- Perinatal conditions and Sudden Infant Death Syndrome are the leading causes of death for Aboriginal infants. Some provinces such as British Columbia and Manitoba have found that Aboriginal infants are over-represented in SIDS deaths. Placing a baby on its back to sleep, avoiding exposure to tobacco smoke during and after pregnancy, not letting a baby overheat, and breast-feeding can reduce the incidence of SIDS.[54]

- there has been a fall in the number of SIDS related deaths in Alberta's non-Aboriginal population, thereby making the Aboriginal portion of SIDS related deaths appear higher.[55]

Birth Weight

- low birth weight. Rates of low birth weight among First Nations and Inuit babies are comparable to the national rates. In 1993, the percentage was 5.4% compared to 5.7% in the non-Aboriginal population. However, the First Nation's rate has increased steadily since 1990, closing the gap with the national rate. Low birth weight is linked with neonatal mortality and morbidity, as well as lasting neurological deficits.[56]

- high birth weight. High birth weight (i.e. over 4,000 grams) is also an issue. In 1996, about 15% to 23% of First Nations babies had high birth weights. In a 1999 study it was found that twenty-two percent (22%) of First Nations and Inuit male infants and 14% of female infants weighed more than 4,000 grams at birth, compared to 16% and 8% of male and female babies respectively in the Canadian population. High birth weight is associated with gestational diabetes, maternal overweight and prolonged gestation and can lead to adverse health consequences. MacMillan et al report increased neonatal mortality rates, a higher incidence of birth injuries and intellectual and development problems in high birth weight babies.[57]

Exposure to healthy breast-feeding

- Breast-feeding offers many benefits: it provides infants with optimum nutrition, it protects against infectious and allergic diseases and in promotes maternal-infant attachment. Breast-feeding may also provide some protection against Sudden Infant Death Syndrome (SIDS). According to the 1999 First Nations and Inuit Regional Health Survey (FNIRHS), 54% of children up to 2 years of age had been breast fed, compared to 75% of children in the 1994-95 NLSCY. FNIRHS mothers were less likely than NLSCY mothers to initiate breast-feeding. Of the First Nations and Inuit children who had been breast-fed, 39% had been breast-fed for over 6 months, compared to only 24% of the children in the NLSCY.[5859]

Exposure to Environmental Contaminants:

- PCBs, mercury, methylmercury. Causes developmental problems and has toxic effects on the immune system, particularly for newborns. Example: between 1993 and 1996, concentrations of PCBs in newborns in Quebec Inuit and Montagnais of Lower and Mid Shore of the St. Lawrence River were found to be four times higher than concentrations in Southern Quebec infants. These levels are over the

threshold beyond which cognitive impairments are expected to result. Also, concentrations of mercury in Quebec and Northwest Territories are six to fourteen times higher than levels in the newborn Southern Quebec population. Again, these levels are above the threshold for the appearance of neurological impairments.[60]

- heavy metals and organochlorides[61] While the precise health effects of these substances remain a matter of considerable debate it is well established that fetuses and young children are especially vulnerable. Another effect of the information on pollutants is that many Inuit people have taken it upon themselves to limit their consumption of country foods, believing that canned and other goods brought in from the South is better for their health. This has resulted in a situation where potentially misleading information is causing individuals to adopt eating habits that may be less healthy than their traditional diet, while the underlying causes and dangers posted by contaminants remains unaddressed.

Nutrition

- iron and Vitamin D deficiency are thought to be widespread among Inuit infants due to the insufficient energy intake of their mothers.[62]

Illness, Disease and Psychosocial Issues

- tuberculosis. Current incidence of TB among First Nations persons on reserve...are 18 times higher than Canadian born non-Aboriginal populations. Rates are higher among the very young (0 - 4) and the elderly.[63]

- Fetal Alcohol Syndrom(FAS)/Fetal Alcohol Effects(FAE). FAS is a condition that results in lifelong disability and is diagnosed in response to a constellation of features: growth deficiencies, developmental delays, neurological, behavioural and intellectual deficits, skull or brain malformations and characteristic facial features. A diagnosis of FAE is made when some but not all of these features are found and is often first diagnosed during the school years. The incidence of FAS appears to be much higher in some Aboriginal communities than in other parts of Canada. A 1997 study of a First Nations reserve in Manitoba found that 1 in 10 children was the victim of FAS or FAE, or roughly 100 cases per 1,000 births on the reserve. In contrast the rate of FAS in western countries is about 0.33 cases per 1,000 births.[64]

- Respiratory illness is the single greatest cause of hospitalization for young Aboriginal children, as it is for non-Aboriginal children. In 1997, 15% of First Nations and Inuit children under six had asthma. Bronchitis for the same population affected almost one in ten children under 6.[65]

- Disorders of the nervous system are common reasons for the use of medical services in children up to the age of 14.[66]

- Although the majority of Aboriginal parents reported that their child or children had no emotional or behavioural problems, a substantial minority reported problems: 9% of children from birth to 5 years had problems.[67]

- "Inuit children start smoking as early as five years old and by the time they are teenagers 69 per cent are smoking regularly."

Literature Review for the First Nations and Inuit Health Branch, Health Canada, excerpts only

Brenda Beauchamp
Aurora Consulting
February 2001

3) Parents as Teachers (PAT)

Background

Parents as Teachers started in 1981 in the United States. Its mission is to bridge the gap between neuroscience and education to enhance parenting and improve outcomes for young children. A *Born to Learn* Curriculum was developed by the Parents as Teachers National Centre, Inc. and a team of neuroscientists from the Washington University School of Medicine, St. Louis. Neuroscience principles have been translated in the curriculum into language that parent educators and parents can understand and apply. The Born to Learn Curriculum covers the prenatal period and is then broken into a number of early childhood stages: book one is 0-14 months and book two is 15 months to three years.

Vision: All parents will be their child's best first teachers.

Program goals

- Give the child a solid foundation for school success
- Increase parents' competence and confidence in giving the child the best possible start in life
- Increase parents' knowledge of child development and appropriate ways to stimulate learning
- Promote a strong child-parents relationship
- Develop true partnership between parents and schools
- Provide a means for early detection of potential learning problems
- Prevent and reduce child abuse and neglect

Basic concepts

- Children are born learners
- Children learn the most from the people they love: their parents
- Parents are the experts on their own children
- All parents deserve support in their parenting role
- Diversity and cultural differences are valued
- All families have strengths, and all parents want to be good parents
- A support program should increase a family's ability to cope, rather than provide a system upon which the family becomes dependent.

Components of PAT

- Personal visits: Personalised home visits by certified parent educators, trained in child development, help parents understand what to expect in each stage of their child's development.
- Group meetings: Parents get together to gain new insights and to share their experiences, common concerns and successes.

- Screening: PAT offers periodic screening of overall development, language, hearing and vision. (Goal of early detection of potential problems which may impact mainstream school experience).
- Resource Network: Families can access other services integrated with PAT in a broader early childhood program.

Evaluation of PAT

The PAT program was evaluated in 1985, 1989 and 1991. Some of the results included:

- at age three, PAT children performed significantly higher than national norms on measures of language and intellectual abilities.
- more than one half of the children with observed developmental delays overcame them by age three.
- parent knowledge of child development and parenting practises significantly increased for all types of families.
- There were only two cases of abuse and neglect among 400 families over a three-year period.
- PAT parents held a positive view of the school district.

Long-Term Impact (1993) with a focus on children's early school experiences and parents' involvement in school and activities to support learning in the home. (Excepts only)

- PAT children scored high on measures of complex and challenging tasks
- PAT parents demonstrated high levels of school involvement
- PAT graduates were less likely to receive remedial reading assistance or to be held back a grade
- PAT "graduates" continue to significantly out perform non-PAT children (on the Stanford Achievement test) in grade four

The results were similar when carried out on high need families with the addition that PAT families substantially reduced welfare dependence and half the number of suspected child abuse and neglect cases.

4) Montessori Education

Main premises

- Children are to be respected as different from adults and as individuals who differ from each other
- The child possesses an unusual sensitivity and intellectual ability to absorb and learn from his environment that are unlike those of the adult both in quality and capacity
- The most important years of a child's growth are the first six years of life when unconscious learning is gradually brought to the conscious level.

Why is it unique?

The whole child approach - the primary goal is to hlp each child reach their full potential in all areas of life. Activities promote the development of social skills, emotional growth, and physical coordination as well as cognitive preparation for future intellectual academic endeavours...and ensures the development of self esteem.

The prepared environment - In order for self directed learning to take place, the whole learning environment - classroom, materials and social setting/atmosphere - must be supportive of the child...the teacher and child form a relationship based on trust and respect that fosters self confidence and a willingness to try new things.

The teacher - the Montessori teacher functions as a designer of the environment, resource person, role model, demonstrator, record-keeper and meticulous observer of each child's behaviour and growth. Extensive training is required for a full Montessori credential, including a minimum college degree and a years' student teaching under supervision - is specialized for the age group with which the teacher will work, i.e. infant and toddler, pre-primary, or elementary level.

Over fifty years ago, Dr. Montessori initiated what was to become a two-year, full-time, course for adults living or working with children from birth to three years of age. This Assistants to Infancy course is attended by parents, birth and early childhood development professionals, Montessori teachers, administrators and teacher trainers. A graduate is awarded an AMI (Association Montessori Internationale) diploma. It consists of almost eight hundred hours of lectures, material making, and observations, plus homework, readings and papers. It also counts for the major part of a Master's degree in education from Loyola College in Baltimore, USA.

Motivation

Montessori children are unusually adaptable. They have learned to work independently and in groups. Since they've been encouraged to make decisions at an early age, these children are problem solvers who can make choices and manage their time well. To facilitate the transfer (to public schools), good communication between the Montessori school and the traditional schools

in a community must be maintained. Montessori parents and teachers can visit the traditional schools and prepare the child for whatever will be different. Teachers from traditional schools can be encouraged to visit the Montessori classes to observe the level of academic work.

Parent education and involvement

The parent of a Montessori student will have an opportunity to be involved in the program. Parents learn more about Montessori by attending orientation meetings, open houses where the children, as the host to their parents and siblings, present their favorite activities, parent discussion groups dealing with aspects of child rearing, home environment and child psychology, and by attending and observing the classes. Parents also receive a regularly published newsletter. In addition to parent education, parents form Parent Associations which coordinate volunteer activities, plan and carry out fundraising programs, and lend support to school staff.

5) Waldorf/Steiner schools

Background

Rudolph Steiner, (1861-1925), a noted Austrian-born philosopher, educator and scientist, developed the first school in 1919 for children of factory workers. The Waldorf/Steiner school movement gained momentum and rapidly spread worldwide. Today there are over 800 schools and 1,200 kindergartens throughout the world.

Main premises

- Changing society requires fundamental changes in the way children are educated
- To awaken what lives in each human being and what can be developed in him/her
- Schools should cater to the needs of the children rather than the demands of the government or economic forces
- A child deserves respect and dignity
- Children should be reached through their senses

Goal: to produce individuals who are able, in and of themselves, to impart meaning to their lives.

Why is it unique?

Waldorf schools incorporates the philosophy of Anthroposophy - “wisdom of the human being”, a way by which humankind can find a philosophical, spiritual-scientific path on which individuals can seek their own relationship between themselves and the world without adhering to one single ideology or solution.

Steiner education is based on a holistic approach, balancing artistic, academic and practical work educating the whole child, hand and heart as well as mind. Its innovative methodology and developmentally-oriented curriculum, permeated with the arts, address the child's changing consciousness as it unfolds, stage by stage. Imagination and creativity are cultivated as well as cognitive growth and a sense of responsibility for the earth and its inhabitants.

The environment - the teacher creates a safe, caring environment for the children and advances with the class for the next eight years delivering the main lesson (known as 'looping'). The children are given constant support and a lot of socializing. One of the outcomes is the building of solid long-term relationships which also teaches students how to acquire the same.

The teacher - the teacher's main purpose is to create within their students a love of learning and a sense of wonder about each subject. Teachers have to have a bachelors degree and then attend Steiner College for another three years to achieve certification. Teachers are taught to present lessons as topics for open discussion and to create an atmosphere in which the moral principles in a given subject can be pondered and felt.

Activities which are often considered "frills" at mainstream schools are central at Steiner schools: art, music, gardening and foreign languages to name a few. Steiner also believed that imagination is at the heart of learning and this concept is at the heart of the schooling. In kindergarten, students work on an art project almost every day preparatory to producing their own workbooks (texts) later. The exposure that they get to storytelling develops listening skills as a prelude to learning to read. As the students develop, they learn to play the recorder and help with chores, such as cooking and gardening. While this provides practical life experience it underscores a primary tenet of life, that it takes persistence and effort to be able to reap rewards.

Art, music and movement, (eurythmy) continue to be incorporated into the work of older students for example in mathematical games, rhymes and designs. Texts produced by students summarize what they have learned and contain their own learning illustrations. Children are not pushed to read but arrive at it at their own pace. Watching television at home, which is not an active learning activity, is discouraged. Computer use does not occur until Grade 8. Emphasis is placed on teaching children to think for themselves and develop an internal motivation to learn, minimizing the need for competitive testing and grading. In fact, students are not graded on their work until the seventh grade and competitive sports occur only in the upper grade levels.

Motivation

Steiner graduates typically exhibit the characteristics of confidence in their abilities, intellectual resourcefulness, unusually long attention spans and a passion for learning. Generally, moving from primary school to secondary school is a fluid process although it can be problematic when transferring from one school system to another at lower grades. Graduates score well above average on national Scholastic Aptitude Tests and do well on college admissions.

Parent Education and involvement

Steiner schools have no principal and are not hierarchical. Rather, they are self-governing entities with each one having its own individual characteristics, although each follow to some extent the pattern of the first Waldorf school. The schools are structured along three lines:

- an administrative section, which consists of parents, one or more teachers and an administrative representative
- management committee, which is run by a system of mandates on an equal standing and with equal rights but having different responsibilities
- faculty

The school is seen as a partnership with people responsible to each other and the school.

Founding a Waldorf school consists of taking incremental steps and can take up to seven years. Initially, it take the form of a parents' study group where books about Waldorf education are read, speakers are invited, Waldorf mentors are provided and most importantly, anthroposophy is studied. The next step is the founding of a playgroup of 4-8 children, which meets in a home, led by a person who is involved in a Waldorf training program. Creating a kindergarten requires a large financial investment, not just in the physical structure of the school but in the training of teachers. The biggest step, to found a licensed school, requires the establishment of a first grade and enough students, teachers for successive eight grades.

6) Families and Schools Together (F&ST)

Background

Families and Schools Together Canada, a national partnership programme of Family Service Canada, is an innovative and collaborative prevention and parent involvement program in which whole families gather at a school and participate in specific, fun, research-based activities aimed at strengthening families, empowering parents and building community. Families and Schools Together Canada combines and applies several concepts that have been evaluated, statistically tested and found to be effective in promoting child resilience, and preventing school failure, behavioural problems and substance abuse. Research on play therapy, empirically tested family therapy techniques, stress reduction through group support and a strategy of parent empowerment provide the program's foundation.

The programme begins with outreach in which parent-professional partnerships (generally including a FAST graduate parent, mental health agency, substance abuse agency and a partner from the school) visit homes of isolated, stressed families, who are identified by school personnel, and invite them to the FAST meetings. The programme brings together 10-15 families

for 8-11 weekly sessions of carefully crafted social activities. When families graduate from the weekly FAST sessions, they join an ongoing, collective of 40-50 interdependent families who meet once a month for 2 years. These FASTWORKS groups are managed by families who have graduated from the programme, with support from a collaborative of culturally compatible parents and professionals.

Features of FAST

Baby FAST (0-3 years)

Goal: to improve family functioning at multiple levels to ultimately enhance the functioning of the infant. The process aims to:

- Support and empower new parents to be in charge of their children
- Encourage positive play and communication between a new mother and her infant
- Encourage the exchange of advice with other parents in the same life cycle stage
- Promote familiarity with community professionals in an informal setting
- Encourage pleasant exchanges with the new mother and her support person (preferably her own mother and the new grandmother)

On the Baby FAST team, half the members are from the formal social network and the others are from the informal side. There are six core partners and it is critical that the collaborative team be culturally representative of the families being served.

Early Childhood FAST (3-5 years)

Goal: to achieve improved child outcomes in the home, in the early childhood programme, in the transition to elementary school, and in the community, Early Childhood FAST builds and strengthens the central protective factor of family cohesion by:

- Increasing parental involvement on multiple levels
- Reducing the risk factor of chronic daily stress
- Reducing the risk factor of substance abuse by the child and the family
- Reducing the risk of chronic family conflict

A collaborative team of 5 core partners runs the 10 weekly sessions. Again, cultural representation is crucial.

Family Systems Theory of FAST:

Ten family system principles, based in structural family therapy, enacted at FAST sessions are as follows:

- Giving all participants the opportunity to create new ways of interacting with each other through experiential activities

- Clearly defining the family unit boundaries in relation to outsiders
- Empowering the subsystem with support
- Clarifying hierarchy
- Bringing order to chaos with foreshadowing, routine and clear responsibilities
- Facilitating empathetic responsiveness and broadening the range of expressed family effect
- Structuring communication to include talking, listening, and inquiring of each other in turns
- Differentiating among individuals in the family
- Combatting disengagement with cohesion-building enactments
- Building family rituals with repeated shared experiences
- Challenging family shared beliefs, encouraging families to embrace new perceptions of themselves as winners, and as having power to initiate activities
- Facilitating connections between families in a positive way

Community Partnerships:

- Strong partnership and collaboration among provinces
- Collaboration, and sense of teamwork amongst Canadian family service agencies
- Individual family service agencies that believe in the program
- Educators that believe in the program
- Alcohol and Substance Abuse educators who believe in the program
- Family Service Canada has offered financial subsidies to assist program start up
- The Trillium Foundation in Ontario is providing funding to all Family Service Ontario agencies with a mandate to provide 21 certified trainers in the next three years

Business Partnerships:

- 1999 Received major sponsorship/funding from the Canadian Pacific Charitable Foundation in the amount of $ 207,000.00 over two years
- Petro-Canada offers ongoing informal, public support and has provided support in funding trip to Conference Board of Canada to present on the program
- Continues partnership with Alliance for Children and Families (Wisconsin).

Diversity of Local Funding

- Local government funding
- Education
- Private Foundations
- Community Based Donors
- Community Groups

Outcome Measures/Research

Outcome measures indicate significant overall improvement in child's behavior in the school and families involvement in school and community. For example,

- Attendance by parents at parent-teacher conferences increased by 1/3 from 60% to 80%
- Belonging to a parent-teacher organization increased from 20% to 40%
- Taking part in activities of parent-teacher organizations increased from 20% to 60%
- Parents reported a notable increase (200+%) in how often they work on arithmetic or math with their child

7) Centres of Excellence for Children's Well-Being (Health Canada)

What is it?

The Centres program is the federal government's first contribution to the National Children's Agenda (NCA). Its mandate is to effectively disseminate advanced knowledge on key issues of children's health to those individuals or groups who need it most. There are five Centres of Excellence for Children's Well-Being. Each Centre is focussing on a different issue: child welfare, communities, early childhood development, special needs, and youth engagement. Each Centre is responsible for: collecting and analysing data, conducting original research, providing policy advice, disseminating information, and developing networks of individuals and groups who are working on the same issue. The Government of Canada has committed $20 million over a five year period to the Centres program. Each Centre of Excellence will receive $500,000 - $800,000 per year.

Unique features

Centres are dynamic, "virtual" networks. They link experts in children's health regardless of the region in which they live, the sector that they represent, or their specific area of expertise. The approach of the Centres is collaborative and horizontal. The emphasis is on forming and maintaining strong partnerships. Centres work is intended to complement existing and emerging federal, provincial, and territorial initiatives.

The Centre of Excellence for Early Child Development will operate under the administrative leadership of the University of Montreal, in partnership with the:

Canadian Childcare Federation in Ottawa, Ontario;
Canadian Institute of Child Health in Ottawa, Ontario;
IWK Grace Health Centre in Halifax, Nova Scotia;
University of British Columbia in Vancouver, British Columbia;
Conseil de la Nation Atikamekw in Wemotaci, Quebec;
Queen's University in Kingston, Ontario;
l'Hôpital St-Justine in Montreal Quebec;
Institut de la santé publique du Québec in Quebec, Quebec;
Canadian Paediatric Society in Ottawa, Ontario;
Centre de Psycho-Éducation du Québec in Montreal, Quebec.

These organizations make up the core group that will provide direction to the work of the Centre.

Giving children the best start in life is one of the most important investments we can make in Canada's future. Research shows that early childhood is the developmental stage with the greatest long-term impact on quality of life. The Centre of Excellence for Early Child Development will help support parents and families to raise children with happy and healthy lifestyles by

providing useful, readable information on this important developmental stage.

Using traditional communication products such as articles, newsletters and workshops, as well as state-of-the-art multi-media including videos and CD-ROMs, this Centre will consolidate expert knowledge on early child development and disseminate it broadly to parents and service providers.

Using a unique approach and integrated view of child development to address the wide spectrum of determinants affecting children's health, the Centre's first year will be devoted to issues related to the period of life from before birth to age one. The second year will focus on age one to age two, and so on, so that at the end of five years a complete package of materials will have been created following children from conception to age five.

Other organizations that will contribute to the work of this Centre include the Fondation Jules et Paul-Émile Léger, the Association for Infant Mental Health, the Montreal Hospital for Sick Children, the Federation of Saskatchewan Indian Nations and the Vancouver Board of Trade. Many of the consortium's 54 partners will contribute financial and in-kind resources over the five-year lifespan of the Centre. These contributions will supplement the funding provided by Health Canada.

8) Roots of Empathy

Background

In the fall of 1996, the Maytree Foundation supported Mary Gordon in the development of the Roots for Empathy program. It was piloted in two schools in Toronto. The program is targeted for classrooms from kindergarten to grade 8.

What is it?

Roots of Empathy teaches human development and nurtures the growth of empathy. It helps educate children for their possible future role as parents. While it fosters the development of empathy, it also helps to reduce aggression both inside and outside the classroom, and provides a tangible experience within which to teach the fundamentals of human development.

Roots of Empathy values:

- We honour the family
- We teach that there is no right way to parent
- The positive models of caring in the family visits can benefit children who have not had responsive parenting
- Developing empathy leads to less aggressive behaviour

- It is more than just a "baby field-trip." Each child has a unique experience, and it is an experience that all children can understand and contribute to
- Real, concrete examples enhance learning. The visits are a three-dimensional, concrete experience. For example, students get to pack the diaper bag, unfold a diaper, offer a toy, sing to the baby, etc
- Every student has a voice
- The teaching situation is fun and participatory
- We incorporate and teach recent findings about neuroscience and child development
- The values and contributions of all the people involved are recognized equally

Structure

Roots of Empathy revolves around the following people:

a baby aged two to four months, the baby's parent(s), a class of elementary school children and their teacher, and the Roots of Empathy instructor.

An initial visit is made to a home which is chosen by the Roots of Empathy instructor. For a period of ten months, the participating family (parents and baby) and the instructor visit a classroom, either kindergarten or elementary school level. There are two monthly visits by the Roots of Empathy instructor to the classroom, before and after each family visit. Ongoing communication is maintained between the instructor and the family, as well as between the instructor and the classroom teacher and the school principal.

Roots of Empathy themes supported by curriculum:

1. Meeting the baby
2. Crying
3. Caring and planning for the baby
4. Emotions
5. Sleep
6. Safety
7. Communication
8. Who am I?
9. Good bye and good wishes

The Roots of Empathy instructors often have experience in teaching early childhood development, social work, health, etc. In order to obtain their certification, potential instructors receive three days of intensive training from qualified Roots of Empathy trainers. Upon completion, potential instructors write a test, and are supervised and evaluated by their mentor (a critical element of the Roots of Empathy program) - once during a family visit and once in a pre- or post-family visit. At the end of the process they receive certification for three years. A one-day re-certification course is completed at the end of three years.

Roots of Empathy is sponsored by The Maytree Foundation and the Criminal Justice System.

9) Saskatchewan Prekindergarten Program

Vision

Prekindergarten in Saskatchewan Community Schools incorporates a comprehensive range of best educational practices to support young children's total development and to lay the foundation for school success and life-ling learning. It provides a holistic, responsive, developmentally appropriate and caring learning program. The focus is on the healthy development of the whole child – physically, socially, emotionally, spiritually and intellectually. Family members and care givers are active participants in the children's development and are provided with parenting skill development opportunities and social and health supports. Development and support for prekindergarten is the shared responsibility of school divisions, community agencies, family members and the province.

Goals

- School and life success for children at risk

  Children at risk are able to achieve their full potential and to succeed in school and in life due to appropriate developmental opportunities and supports provided for them at an early age.

- High quality prekindergarten programming

  Prekindergarten early childhood programming is of the highest quality - holistic, responsive, developmentally appropriate and culturally affirming.

- Increased parenting effectiveness and shared responsibility

  Through their active involvement in the prekindergarten program, parents enhance their parenting skills and share responsibility for the well-being and education of their children.

Principles and Strategies

- Child-centred/Family focus

  Age group is children three and four years old. Prekindergarten affirms that children are usually best served in the context of their families.

- Cooperation and Shared Responsibility

  Teachers work in partnership with family members, the parent council and community agencies to strengthen the learning program and to provide the range of supports students need.

  Through shared funding and support for programming, school divisions, community organizations and the province demonstrate their shared responsibility

for early intervention initiatives.

- Equity and Respect for Diversity
  The unique potential, cultural heritage, gender, life experience and capabilities of each child and adult are respected and reflected in the program and environment.

- Preventive, Responsive and Holistic Approaches
  Programs and services are designed to anticipate and offer supports to young children before significant problems develop which require major intervention. A comprehensive range of supports and services is provided in a coordinated and integrated manner to holistically meet the needs of children and their families.

- Continuous Learning
  Children's growth and learning are continuous processes. Learning begins at birth and continues through life.

- Accountability: Continuous Assessment and Renewal
  Educators, school councils, parents, boards of education and community members each have a role in ensuring that the prekindergarten program meets the needs of children in preparing them to succeed in school. There is continuous assessment of the effectiveness of the program in meeting its objectives and improvements are made to ensure the very best educational practices for children at risk.

Parent and Family Involvement

Objectives
- foster shared responsibility for the development and well-being of the children
- provide opportunities for parents to participate directly in their children's learning and to be perceived by their children as role models and "teachers" as key people in the learning program
- provide learning opportunities for parents to develop and enhance parenting and other skills
- encourage shared ownership for the prekindergarten among families

This approach reflects the importance of family and parent involvement in the development of children. Teachers also benefit from direct contact with families, gaining greater knowledge and understanding of the children, their families and the communities in which they teach. For children at risk, parent involvement is the single most important factor in their school success. The "best practices" for effective parent involvement include: parents in the classroom; home visiting/liaison; parent/school council; and, family education programs.

Community partnerships and Integrated Services

Cooperative and collaborative arrangements with community agencies and human service providers extend the capacity of the prekindergarten to meet the needs of the whole child in a holistic and coordinated manner. Forming partnerships with community groups such as churches, businesses and community service organizations, as well as collaborative relations with community human service agencies such as Social Services and Mental Health are critical to the success of prekindergarten. “Best practice” characteristics include: coordination and integration of community services and resources; community partnerships; and, effective case management.

Qualified Teacher and Teacher Assistant

Funding to school divisions is directed toward the hiring of qualified teaching staff including a certified teacher with specialty in Early Childhood Education and a teacher assistant with a minimum of grade 12 and a significant knowledge of the community and the children’s culture and experiences.

Saskatchewan government financial commitment - 2002

In 2002, the Saskatchewan government announced an increase in the number of prekindergarten spaces by approximately 80% for the upcoming school year. The government also committed $10 million towards intensive early childhood supports for vulnerable children up to the age of five, and support for their families as well.

10) Family and Child Education (FACE) program

Background

In 1990, the Office of Indian Education Programs (OIEP) of the Bureau of Indian Affairs developed an Early Childhood & Parental Involvement Pilot program. It was later renamed Family and Child Education (FACE). Currently, there are 32 existing FACE sites in the United States, each of which receives $250,000 U.S. annually.

Description

The FACE program is an innovative school reform model and a family literacy program that serves children from birth to 8 years of age and their parents/ primary caregivers.
It has created an integrated continuum of educational and social supports through the implementation of four program components:

- Early childhood education
- Parent and child time
- Parenting skills
- Adult education

The program also includes screening and referrals.

Through a collaborative effort, three nationally acclaimed U.S. program - Parents As Teachers (PAT), the National Center for Family Literacy (NCFL) and Engage Learning - partner with the OIEP to provide intensive and on-going training and assistance to support the implementation of the FACE program.

Parents As Teachers (PAT)
PAT provides the training and technical assistance for home-based services, which are delivered to families with children from birth to 3 years of age. Service is delivered through:

- Bi-monthly home visits (use the *Born to Learn* curriculum)
- Periodic screening of overall development of the child
- Referrals to school and community services
- Monthly parent meetings

National Center for Family Literacy (NCFL)
The NCFL provides training and support for the implementation for centre-based services, which are offered at the school facilities to children aged 3 to 5 years and their parents. The four components are:

- Early childhood education

- Adult education
- Parent time
- Parent and child interactive time

Engage Learning
Engage Learning provides training and professional development opportunities for teachers to implement the High/Scope curriculum in grades K-3. The High/Scope curriculum supports active learning to address various learning styles and includes children's choice of learning activities, cooperative learning and teacher encouragement of children's use of language - both English and Native languages.

FACE goals

- Support parents in the role as their child's first and most influential teacher
- Facilitate family literacy, native language and culture
- Establish home/ school partnerships
- Prepare youth for academic and social success in school
- Early detection of learning delays
- Prepare parents for employment or continued education

Desired outcomes

Short term:
- Increased reading levels for First Nations students
- Increased parental involvement in their child's education
- Increased literacy rates for parent/ caregivers
- Increased knowledge of ancestral languages and culture

Long term:
- Increased student attendance rates
- Increased rates of school retention and high school graduation
- Increased post-secondary enrollment
- Increased employment opportunities for parents/ caregivers
- Increased number of parents obtaining their high school equivalency

11) Aboriginal Home Instructional Program for Pre-school Youngsters (HIPPY)

Goal: To deliver a home based program designed for the enrichment of preschool children at risk and for increasing their parents' awareness of their own strengths and potential as home educators.

Background

Founded in Israel in the 1960s, HIPPY is a two to three year educational program that relies on community leaders and home-based learning to help disadvantaged parents ready their children for kindergarten. HIPPY was launched in Canada in 1999 in Vancouver at the Britannia Community Centre. Within a few weeks of the launch, the coordinator and home visitors had recruited 63 families from 26 different nations to participate in the program. The 52 families that stayed with the program completed, on average, 17 weeks of the possible 30-week program.

Using educational material aimed at developing three to five year olds' cognitive and coordination skills, trained HIPPY paraprofessionals coach parents in their homes on being their children's first teachers. Parents learn activities that they can do with their children, receiving story books and activity packets to teach and review with their children during the week. The program's success is largely predicated on the close bond that develops between home visitors and HIPPY parents; home visitors are parents previously helped by HIPPY.

The Chief Dan George Centre for Advanced Education at Simon Fraser University (SFU) has proposed a strategic partnership between HIPPY Canada and SFU Continuing Studies Community Education Program to support the implementation of Aboriginal HIPPY Canada as a national program within Aboriginal communities both on and off reserve. A number of pilot programs have been agreed upon for a number of communities in British Columbia (Aboriginal HIPPY British Columbia) who have different qualities, demographics and geographical locations. The cost per site is approximately $175,000.

To support the implementation of Aboriginal HIPPY Canada, a national Aboriginal Children's Website will be developed at the Chief Dan George Centre for Advanced Education in Vancouver. The site will provide information on Aboriginal Early Childhood Development across Canada and links to other indigenous children's programming. It will also provide information on books for Aboriginal children and special partnerships for readings and Aboriginal ECD.

HIPPY results (anecdotal)

In a comparative analysis of children who participated in HIPPY versus children who either participated in preschool or who did not participate in any educational program prior to kindergarten, it was found that:

- HIPPY children, as a group, performed better on cognitive measures
- HIPPY children were better prepared for kindergarten, both academically and socially
- Comments from parents suggest that HIPPY had a positive impact on the quality of child-parent relationships and that it has enabled them to not only spend more

productive learning time with their children but better quality playtime

- Parents feel more connected to their community
- Parents have observed in their children a greater adaptability and application of skills learned in HIPPY, increased attention span, increased self confidence and improved language skills

12) Aboriginal Head Start

Aboriginal Head Start, a Health Canada program, is a federally-funded early intervention strategy to "*provide comprehensive experiences for Indian, Métis and Inuit children and their families…based on caring, creativity and pride flowing from the knowledge of their traditional beliefs within a holistic and safe environment"*. Originally, it focused on Aboriginal children in urban centres and northern communities but it was extended to on-reserve communities in 1998. Its goal is to support early childhood development strategies designed and controlled by Aboriginal people. An estimated $62 million was to be spent on Aboriginal Head Start between 1994 and 1998. In 1998 there were more than 90 Aboriginal Head Start projects across the country.

Funding for the on-reserve Aboriginal Head Start program was set at $100 million over four years beginning with $15 million in 1998/99. When off-reserve Aboriginal Head Start was announced in 1995, funding for a 4 year period totaled $83.7 million: $25.7 million for 1995-96; $23 million for 1996-97; $22.5 million in each of 1997-98 and 1998-99 and an additional $25 million a year ongoing.

Mandate

- Foster the spiritual, emotional, intellectual and physical growth of the child.
- Foster a desire in the child for life long learning.
- Support parents and guardians as the prime teachers and caregivers of their children, making sure parents/caregivers play a key role in the planning, development, operation and evaluation of the program.
- Recognize and support extended families in teaching and caring for children.
- Make sure the local Aboriginal community is involved in the planning, development, operation and evaluation of the program.
- Make sure that the initiative works with and is supported by other community programs and services.
- Ensure the human and financial resources are used in the best way possible to produce positive outcomes and experiences for Aboriginal children, parents, families and communities.

Project Features

Each project will focus on preschool children and will include the following components:

- Culture and language

- Education
- Health promotion
- Nutrition
- Social support programs
- Parental involvement

Preschool Projects

There are more than 100 Aboriginal Head Start project sites across the country from the Atlantic, Quebec, Ontario, Manitoba/Saskatchewan, Alberta/Northwest Territories and British Columbia/Yukon regions.

Children Making a Community Whole: A Review of Aboriginal Head Start in Urban and Northern Communities (Excerpts from the Executive Summary)

Children Making a Community Whole reports on the results of the first AHS National Process and Administrative Evaluation Survey, conducted in 1999...At the time of the survey, there were ninety-nine AHS projects in Canada, ninety-six of which participated in the survey. Twenty-one percent of projects are in remote communities with a population less than 9,999, thirty percent are in communities with a population greater than 50,000.

In 1999, a total of 3,236 children enrolled in AHS. Operating at near capacity, the program is able to accommodate less than twelve percent of the Aboriginal three and four-year-olds living off reserve. Forty-four percent of participants are from First Nations backgrounds, thirty-four percent are Inuit and twenty-two percent are Métis. Fifteen percent of the participating children are fluent in an Aboriginal language. Of the thirty languages used in AHS, the most frequently used are Cree, Ojibway, Inuktitut, Michif and Saulteaux. The substantial number of languages in use in AHS reflects the diversity of the program design. Typical AHS projects operate September to June, four days per week, and provide three and four-year-old Aboriginal children with half-day structured pre-school experiences.

Approximately thirty children participate in AHS on any given day in any project. Seventeen percent require greater than normal staff time, mostly for language-related, Fetal Alcohol Syndrome/Fetal Alcohol Effects or emotional, behavioural or developmental delays. When asked to identify program needs and desires, projects almost unanimously call for training and resources to deal with special needs, among other things.

Seventy percent of projects report that getting parents involved is a challenge, but nevertheless eighty-four percent have parent councils that provide opportunities for parents and community members to have meaningful input into design, implementation and management of their local project. Parental involvement is a high priority for the AHS program.

Over seventy percent of the AHS project staff is Aboriginal. The largest number of staff consist of teachers and directors... Thirty one percent of all project staff is trained in Early Childhood Education, and another fourteen percent have undergraduate or graduate degrees. Median Health Canada funds received by all AHS projects for the period April 1, 1998 to March 31, 1999 were $200,000. Community, provincial and federal partners infused an additional $3,825,320 into the program in the fiscal year 98/99 in donated funds, services and resources.

13) First Nations/Inuit Child Care Initiative

The First Nations/Inuit Child Care Initiative, a Human Resources Development Canada program, was announced in 1995. It is intended to achieve levels of quality and quantity of child care in First Nations and Inuit communities that are comparable to those available to the general population. The 3 year initiative, 100% federally funded, was to develop and upgrade child care spaces with a target of 6,000 spaces intended to meet the accessibility level of the general population.

First Nations and Inuit organizations have assumed the responsibility for administration of funds and for developing regulated child care services and related support programs like family resource centres. Funding for the First Nations/Inuit Child Care Initiative is not intended to replace existing funding programs under DIAND.

The First Nations/Inuit Child Care Initiative funding was part of the $720 committed to child care in the 1993 election campaign but, except for the First Nations/Inuit Initiative, not spent. The First Nations/Inuit Child Care Initiative had a financial commitment of $6 million for 1995-96; $26 million for 1996/97; and $40 million for 1997-98. On-going funding of $36 million annually will be available after this 3 year period.

14) Inuit Tapirisat Kanatami - Inuit Early Childhood Development Issues Discussion Paper (March 2001)

Executive Summary

The Inuit Early Childhood Development Project (IECD) has identified a wide number of important issues that impact upon the health and welfare of Inuit children. It is imperative that steps be taken as soon as possible to try and resolve these issues. Any delay in providing an effective response will undermine Inuit society at large and impede its ability to reach its full potential.

The responsibility for meeting these needs must be shared by a number of people and agencies as the following suggests.

The time is now for Inuit parents and community leaders to plan for the development of comprehensive community- based strategies designed to address and resolve childrens issues, in order to pave the way for healthy Inuit child development.

The time is now for Inuit political leadership to take action on Inuit children's issues and elevate children's needs to the first place on the list of top priorities.

The time is now for Inuit organizations to follow the lead of the Nunavut Aboriginal Human Resources Development Agreement (AHRDA) Holders and come together to create the winning circumstances needed to assure that Inuit children have the opportunity to develop to their full potential.

The time is now for the Government of Canada to recognize that representatives of Inuit organizations need a mechanism, which assures their ability to meet at regular intervals and provide direction to the development of government program and policy related to Inuit child development.

Historically Inuit were totally in control of their lives. During the latter half of the twentieth centuries with the gradual arrival of various government services much of the responsibility shifted. Today, as more government funding is flowing through Inuit organizations, Inuit are regaining responsibility for the world in which they live.

Today the issues affecting Inuit children are broad reaching and insidious. Elders reported concerns about children living in violence and fear. They spoke about the breakdown of the traditional family structure, about language loss and the need to support and ensure that traditional Inuit lifestyle and knowledge are maintained.

During the interview and survey portion of the project: parents, organization, government and community representatives spoke of issues related to *child and health*. They articulated concerns with health particularly related to the absence of appropriate consistent professional support. Other key health problems: oral hygiene, respiratory problems, chronic ear infection, acute anemia in infancy are all related to quality of environmental and nutritional aspects of the young child's life.

The surveys asserted that children are living in communities in which the influence of the non-Inuit culture has been so strong as to undermine Inuit culture and society. It is clear that the continued use and knowledge of traditional skills and language are under great pressure, in large part due to the impact of southern media and the intergenerational impact of the transition from living on the land to within communities.

Furthermore, many parents are not well prepared for parenting roles. The residential system exposed them to an institutional upbringing and traumatized many. This residential experience has left many parents without traditional support systems and prevented the learning of essential parenting skills and knowledge from their own parents.

The Inuit Tapirisat of Canada sponsored this Inuit Early Childhood Issues Discussion Paper Project. The funding originated from HRDC.

What has to happen next?

This document sets out to explore issues related to Inuit Early Childhood Development. It is a first step.

A plan must be developed in collaboration with Inuit representatives from the six regions, as well as from the south, to develop an action plan. A plan that will move the reality of IECD towards that definition where:

> ***Inuit children are thriving***. *Their basic needs for food, shelter, health, love and care are met. Parents have time for children, who live in relaxed, safe environments. The children are healthy, conceived by vitally strong parents, and raised in healthy communities. Inuit children are emotionally secure, physically strong, intellectually stimulated and spiritually fulfilled. The needs of all children are met in an appropriate way and there is an availability and continuity to the services provided. All children including infants have access to children's programs and services. The Inuk child has a positive self-image and lives in and feels pride in his Inuit culture, language and ways*.

Conclusions
...the impact of the residential school system upon Inuit is well known and documented in greater detail elsewhere. Many Canadians understand the inappropriateness of the placement of Inuit foster children in non-Inuit families and communities, and yet such problems continue to persist.

The impact of high levels of unemployment and poverty, severe shortages of adequate housing, high levels of family violence – these have long been identified as major problem areas in the north.

The issues demand attention: they are almost overwhelming.
When one considers the health problems facing many Inuit children, one is forced to conclude that many Inuit children are not beginning life with an opportunity equal to that of other Canadian infants. Some Inuit born with Fetal Alcohol Syndrome/Effect will not recover from the physical disfigurement, intellectual dysfunction and behavioural problems that this syndrome bears.

Other Inuit children, born with special needs, require appropriate, timely diagnosis, treatment and follow-up. This is to ensure that problems can be addressed and resolved during the early years. Currently, in many cases, these problems cannot even be diagnosed, due to the absence of professional help.

The quality of Inuit child nutrition is of great concern and affects both the health of the child and their family.

The issues around violence are worrisome. Children are witnessing violence in their own homes. As well, many children are victims of sexual and physical violence. Although the existence of the problem is obvious, Inuit need access to solid statistical documentation to understand the extent of the issue and to be able to develop effective strategies to address it. There is a need for safe places for children who are afraid or who are in danger.

Some Inuit parents are having a very difficult time trying to provide the best for their children. There have been as many as 30 people reported living in a single three-bedroom house. There are chronic high rates of unemployment in many Inuit regions. This has resulted in a heightened dependency on income support and an unacceptably high percentage of Inuit families living in poverty.

Many parents are not well prepared for parenting roles. The residential system exposed them to an institutional upbringing and traumatized many. This residential experience has left many parents without traditional support systems and prevented the learning of essential parenting skills and knowledge from their own parents.

Many parents lack self-confidence and self-esteem. Some have low levels of formal education and correspondingly low levels of literacy. Others are dealing with issues related to substance abuse including: smoking, alcohol, drugs, sniffing, and gambling.

The influence of the southern non-Inuit culture has been so strong as to undermine Inuit culture and society. It is clear that the use and knowledge of traditional skills and language are under great pressure, in large part due to the impact of southern media and the intergenerational impact

of the transition from living on the land to within communities.

The broad dispersal of the various federal, territorial, provincial funding pots does not contribute to the ability of communities to resolve problems. But there is hope especially as Inuit organizations assume increasing responsibility for funding of programs and services that concern Inuit.

During the past five years, an investment of capital funding through the First Nations Inuit Child Care Initiative has enabled the construction/renovation of many new day care centers. The Canadian Pre-Natal Nutrition Program is functioning in some Inuit communities and Brighter Futures is offering programs in most. In Nunavut, the Healthy Children's Initiative supports the development of Family Resource Centers, as a way of meeting the needs of families and children.

There has been action. The question remains: What must happen for children in Inuit communities to thrive?

- **Communities need to work together, to plan together and to develop a plan, which sets out the actions needed to raise the health and welfare of the Inuk Child in Inuit communities to priority number 1.**

- **The vital importance of the well being of Inuit children in the Inuit communities of northern Labrador, Nunavik, Qikiqtani, Kivalliq, Kitikmeot and Inuvialuit must be recognized as the number 1 priority by the political leadership.**

- **Inuit regions must create opportunities to convene, discuss, and direct positive program and planning outcomes for IECD. This is already happening in Nunavut, where the three Nunavut AHRDA Holders have formed a team dedicated to planning together best possible outcomes for the delivery of licensed child care services in Nunavut.**

- **The national organization, the Inuit Tapirisat of Canada, has an important role to play in bringing together representatives of the Inuit regions and providing sponsorship to the development of a formal Inuit Working Group dedicated to Healthy Inuit Early Childhood Development.**

- **Federal, territorial, provincial, municipal, funding for children's programs 0 –6 needs to be pooled and made more readily accessible, possibly through a single-entry, one-window approach.**

- **Access to appropriate, reliable, consistent, experienced, qualified professional services at all levels must be secured for Inuit children, now.**

- **Action must be taken to ensure that Inuit culture, lifestyles and language thrive.**

- **Programs must be accessible to all.**

- **Inuit in all regions should have equal opportunity to access children's funding. At present federal funding allocated to Newfoundland does not get into the Inuit or Innu communities of Northern Labrador.**

15) Building on Success - Report of the Standing Committee on Human Resources Development and the Status of Persons with Disabilities (June 2002)

As a result of the Government of Canada commitments to Aboriginal people in the Speech from the Throne inaugurating the 37th Parliament, a Sub-committee of the Standing Committee conducted a study of Aboriginal children in Canada with specific attention to federal programs available to them. The study will be conducted in four phases: The condition of First Nations children from the prenatal period to age 6 living on reserve; the condition of young Aboriginal children living off reserve from the prenatal period to age 6; the condition of First Nations children from age 6 to 12 living on reserve; and, the condition of Aboriginal children from age 6 to 12 living off reserve.

Excerpts of the overview:

Time and time again, the members of the Sub-committee were reminded of the disparities in the health and well-being of First Nations children and their non-Aboriginal counterparts. 'By every measure, the BC Aboriginal Child Care Society told the Sub-committee, Aboriginal children in Canada are doing poorly and their families face many different challenges, including poverty, welfare dependency , illiteracy, and family distress.'

In 1996, an estimate placed almost 60 per cent of First Nations children under the age of six below Statistics Canada low-income cut-off rates. This exposure to poverty and its deleterious effects can be traumatic, especially among children who continually live with these powerful stresses.

Other social indicators for First Nations children found that:

- Infant mortality rates are two to three times higher thank the Canadian average.
- The rate of infant mortality due to injury is four times higher than the national average.
- The preschool death rate for First Nations children is five times greater than the Canadian norm.
- The rate of fetal alcohol syndrome and fetal alcohol effects may reach 20 per cent in Aboriginal communities.
- First Nations children on-reserve are taken into care at four times the rate of other Canadian children.
- Nearly 30 per cent of all Aboriginal children live in lone-parent households and 15 per cent of First Nations children on-reserve are living with neither parent.
- 23 per cent of First Nations children living on-reserve have serious learning difficulties.

These social and economic challenges confronting many First Nations children become even more troubling when one considers the current and projected demographic trends. Fully one-third of the population is under 14 years of age...This reality presents serious policy implications for both federal and Aboriginal governments.

Members of the Sub-committee recognize that a sustained, integrated and culturally-sensitive approach to addressing these inequities is urgently required if the lives of First Nations children are not to be characterized by a downward cycle of despair.

Federal Family

The involvement of a number of federal departments in inevitable. These include: Indian and Northern Affairs Canada, Human Resources Development Canada, Heritage Canada, Health Canada, Department of Justice, etc. Sharing responsibilities for programs and services for children demands close collaboration among the various departments. Despite departmental attempts to work horizontally, the Sub-committee found that the support offered by departments is still fragmented. This lack of coordination has led to some communities having trouble finding their way through the maze of available services and programs. Furthermore, departments have overlapping mandates which can result in a series of fragmentary programs and divisions within the communities. All of these factors also made it impossible for the Sub-committee to get an overall view of what the government is doing to encourage healthy development of young First Nations children.

Recommendations of the Sub-committee:

Recommendation one
The Sub-committee recommends that all federal departments with programs for First Nations families and young children living on Canada's reserves join together to create an integrated policy framework for the development of young First Nations children from 0-6. This framework should include a common vision of the results desired, the objective sought and the lines of accountability.

Recommendation two
The Sub-committee recommends that the Government of Canada:

a) Implement culturally appropriate pilot projects in selected First Nations communities across the country. The pilot project should integrate and harmonize, at the community level, various programs and services for children aged 0-6 living on reserve using a community-based multi-service delivery model approach (similar to the province of Quebec's network centres locales de service communautaires). They should also address the needs of children with disabilities.

b) The Sub-committee further recommends that the principles underlying the pilot projects should include the following:

> **(i) The selection of communities, planning and implementation of the pilot projects should take place in consultation with appropriate First Nations organizations.**

(ii) Adequate funding should be made available in order to implement successfully the pilot projects in First Nations communities and to ensure that the selected communities and departments have the budgetary capacity to participate effectively in this initiative.

(iii) Federal departments providing early childhood development programs and services to First Nations pilot projects should consolidate departmental program funding in one envelope. This consolidated funding framework should be multi-year and flexible.

(iv) The integrated framework should include mechanisms for the harmonization of programs and services provided by other governments and stakeholders. This harmonization should respect and the support the work that has been done, and the services already provided, by the various provincial, municipal and Aboriginal authorities and should be jointly agreed upon by the above-mentioned authorities.

(v) Prior to the implementation of the pilot projects, common outcomes should be developed, in consultation with the appropriate First Nations organisations, and agreed to by all the participating federal departments.

(vi) Meaningful performance and results indicators should be developed by all participating federal departments and the appropriate First Nations organisations in order to effectively evaluate the pilot projects and be able to make adjustments where appropriate.

(vii) Requirements for financial accountability and reporting to external agents like DIAND, Health Canada, HRDC, etc., should be harmonized and designed in such a way as to reduce duplication, considering the findings contained in the Report of the Auditor General of Canada, *Managing Departments for Results and Managing Horizontal Issues for Results.*

(viii) A commitment to sustainable funding should be made in order to ensure that pilot projects can be properly tested over a sufficient period of time.

Conclusion

...we firmly believe that the First Nations communities are in the best position to define the need for intervention and the priorities for action. The complex needs and problems of the children and families will be better handled through programs and services that focus on the specific needs of the individual communities. Our recommendations in this report are founded on this premise.

16) Royal Commission on Aboriginal Peoples - Early Childhood Development

In education, as in health, childhood is the foundational stage. Traditional family life provided a firm foundation of security and encouragement for Aboriginal children. Aboriginal families of today are not always able to provide this. Parents may be hampered by the effects of poverty, alienation, residential school experience, and dysfunctional family or other relationships. Many Aboriginal children arrive at school with special needs for understanding and support to liberate their in-born capacity for learning.

Like all children, Aboriginal children need to master the intellectual, physical, emotional and spiritual tasks of early childhood. Equally, they need grounding in their identity as Aboriginal people. We propose that all Aboriginal children, regardless of status or location, have access to dynamic, culture-based early childhood education.

The Commission recommendation that:

> **Federal, provincial and territorial governments co-operate to support an integrated early childhood education funding strategy that**
>
> **- extends early childhood education services to *all* Aboriginal children regardless of residence;**
> **- encourages programs that foster the physical, social, intellectual and spiritual development of children, reducing distinctions between child care, prevention and education;**
> **- maximizes Aboriginal control over service design and administration;**
> **- offers one-stop accessible funding; and**
> **- promotes parental involvement and choice in early childhood education options**

End notes for Brenda Beauchamp's piece on **Aboriginal Health Outcomes for Children**

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