
Early Childhood Care and Development as ‘Hook’ and ‘Hub’ for Inter-sectoral Service Delivery Supporting Aboriginal Population Health

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Where does this research fit?

- **Romanow Report** push for ‘streamlining’ ‘coordinating’ ‘partnering’ toward integrated, accessible services
- Recognized need to make access easier for **rural & remote** families
- Recognized need to create a **cultural frame** around services to culturally specific communities, such as First Nations
- First Nations push for community development, **self-governance**, ‘Aboriginal ways’
- Understanding how **Aboriginal Head Start** programs impact families & communities
- **International/global** push for multi-disciplinary & inter-sectoral concepts & delivery of child & family services

Securing the future of Aboriginal peoples

- **Royal Commission on Aboriginal Peoples** emphasized investments in health, cultural transmission, and education for young children
- 40% of Aboriginals under 20 yrs.
- 3% increase in Aboriginal population in 10 yrs.
- Priority on early years programming as a community development strategy
- First Nation Elder: *“Our children need to be understood as part of a whole that includes their family, community, culture, and the natural environment”*

Promising practices in rural First Nations communities

- Human Resource Development Canada funded research
- Follow-up of First Nations grads of 2 yr. ECD training program with cultural focus
- 3 groups of communities represented by 2 band councils and one tribal association
- $5 + 3 + 6 = 14$ rural & remote community examples
- Northeast, North Central, Southwest B.C.
- All 2-6 hrs drive from a hospital or city centre

Community Locations



Documentation of service capacity, delivery, & perceived impacts

- Interviewed approximately 30 ECE practitioners, service providers, parents, & Elders in each community
- Service record reviews
- Documentation of service mandates, infrastructure, utilization, impacts, & challenges

From Training to Work in ECE

- Interviewed 27 of 34 graduates from training program
- All full-time in ECE relevant work
- Extraordinary retention of trained community members
- ACCS estimates over 200 Aboriginal people in BC with ECE certification and less than 50 working in the field.

Enabling conditions for capacity building & retention

- **Community-based training:**
 - Program achieves a high level of visibility that is not possible when community members are required to leave their community to attend training elsewhere
- **Community-involving training:**
 - Community has a clear sense of commitment to increasing programmatic efforts to promote child well-being and contributing tangibly to training program impacts on community infrastructure
- **Community-participation** in ECD program implementation
- *“There’s much more talk in the communities these days about improving the environment for children. There’s definitely a ripple effect. It took a program like this to get things going.”*

Marie McCallum, Director of MLTC Training

- Immediate, relevant **work opportunities** & availability of **child care**
- **Competitive pay**

Early years programs initiated &/or staffed by program grads

- Out-of-home, centre-based child care & development
- Aboriginal Head Start
- In-home family-based child care
- After-school programs
- Infant Development Programs
- Language enhancement programs
- Heritage language promotion programs
- Individualized supported child care for children with special needs
- School-based teacher assistance/learner support
- Parent support programs

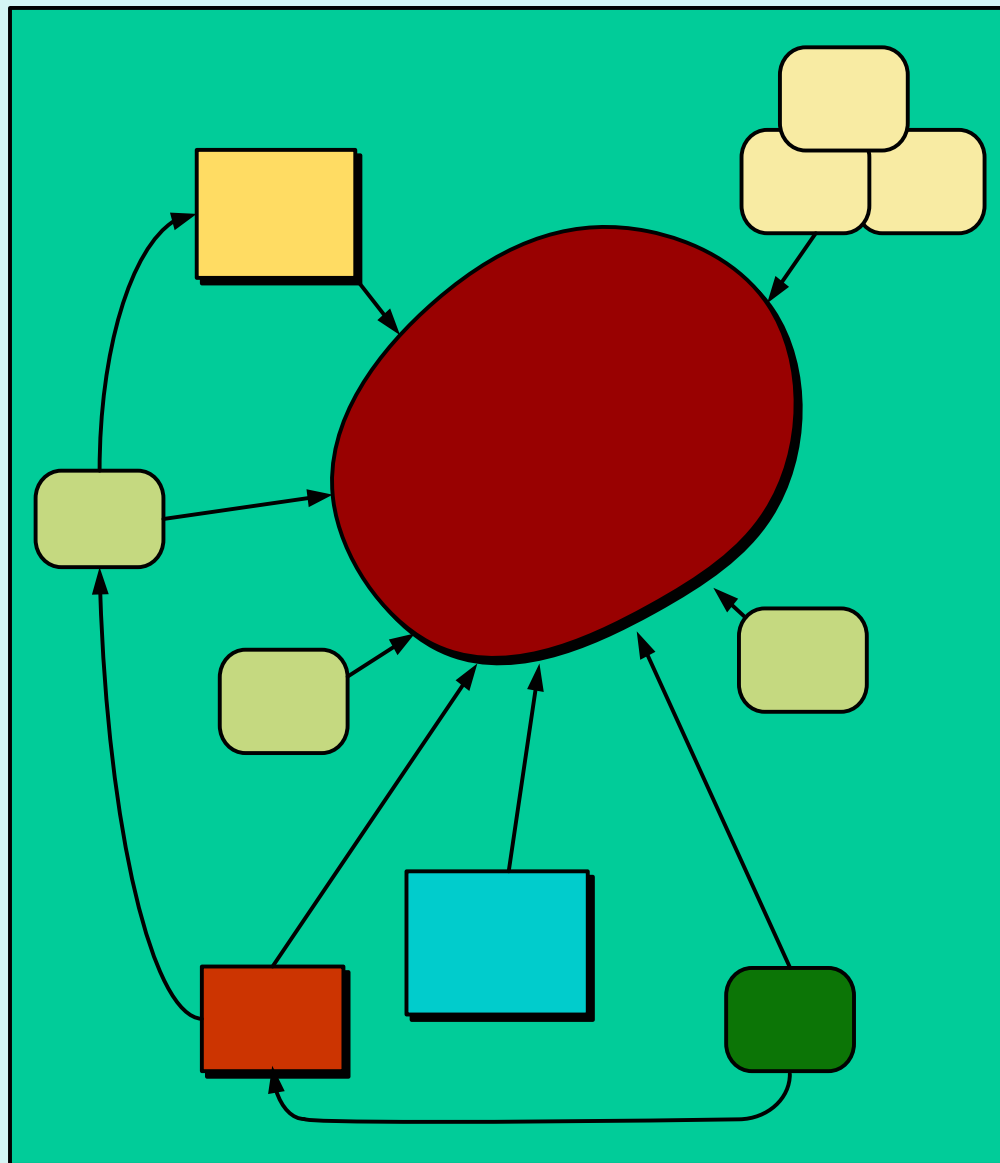
Perspectives

- **All** communities were taking steps via their ECD program initiatives toward coordinating services to increase awareness, access & utilization via their ECD program
- **Evolutionary perspective:**
 - Concepts: Vision / commitment
 - Community well-being: cohesion, cooperation, stability, leadership
 - Resources: Local capacity, Bridges with external service providers & bureaucrats, funding
- **Post-modern perspective:**
 - No ‘best practices’
 - Community development & service delivery models must be custom-built for the particularities of culture, strengths & needs, geographies, size and resources of specific communities.

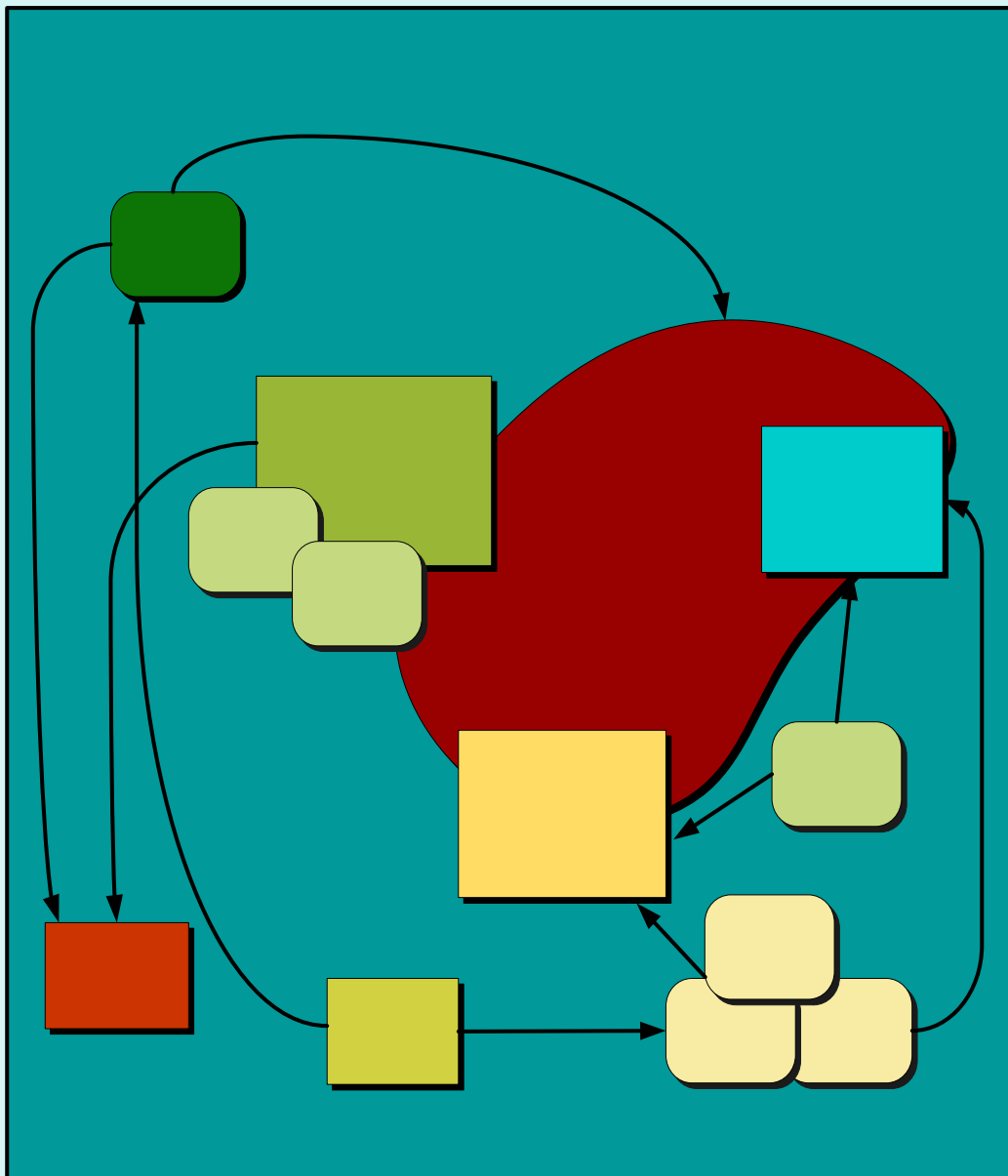
Finding our way to supporting wellness among diverse communities of children & families requires many paths up the mountain. No one approach, no one program model, will reach or work for everyone.

- Tribal Council Administrator -

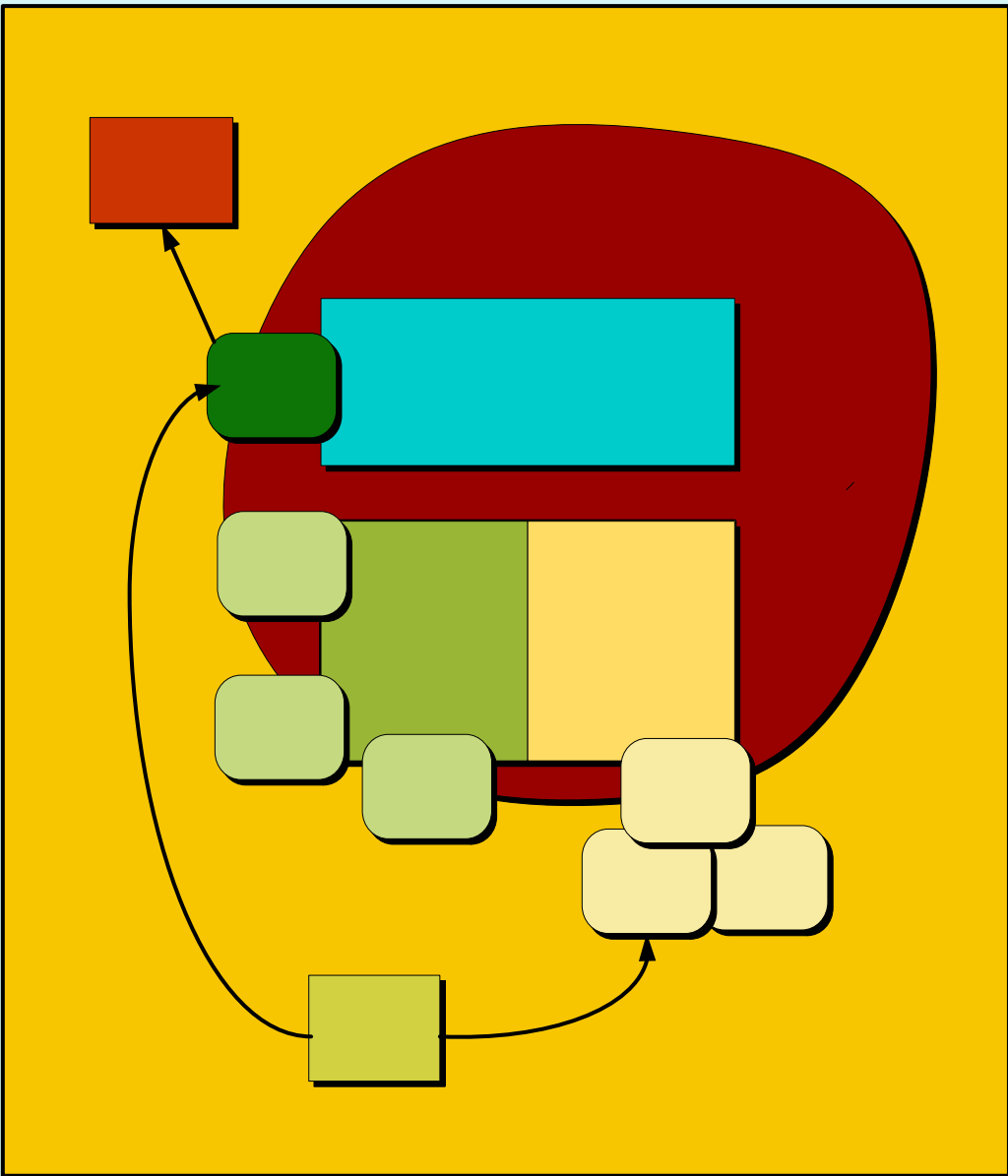
Individual, Fragmented Service Model



Capacity Development Model #1

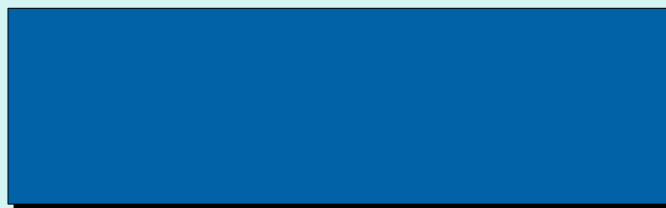
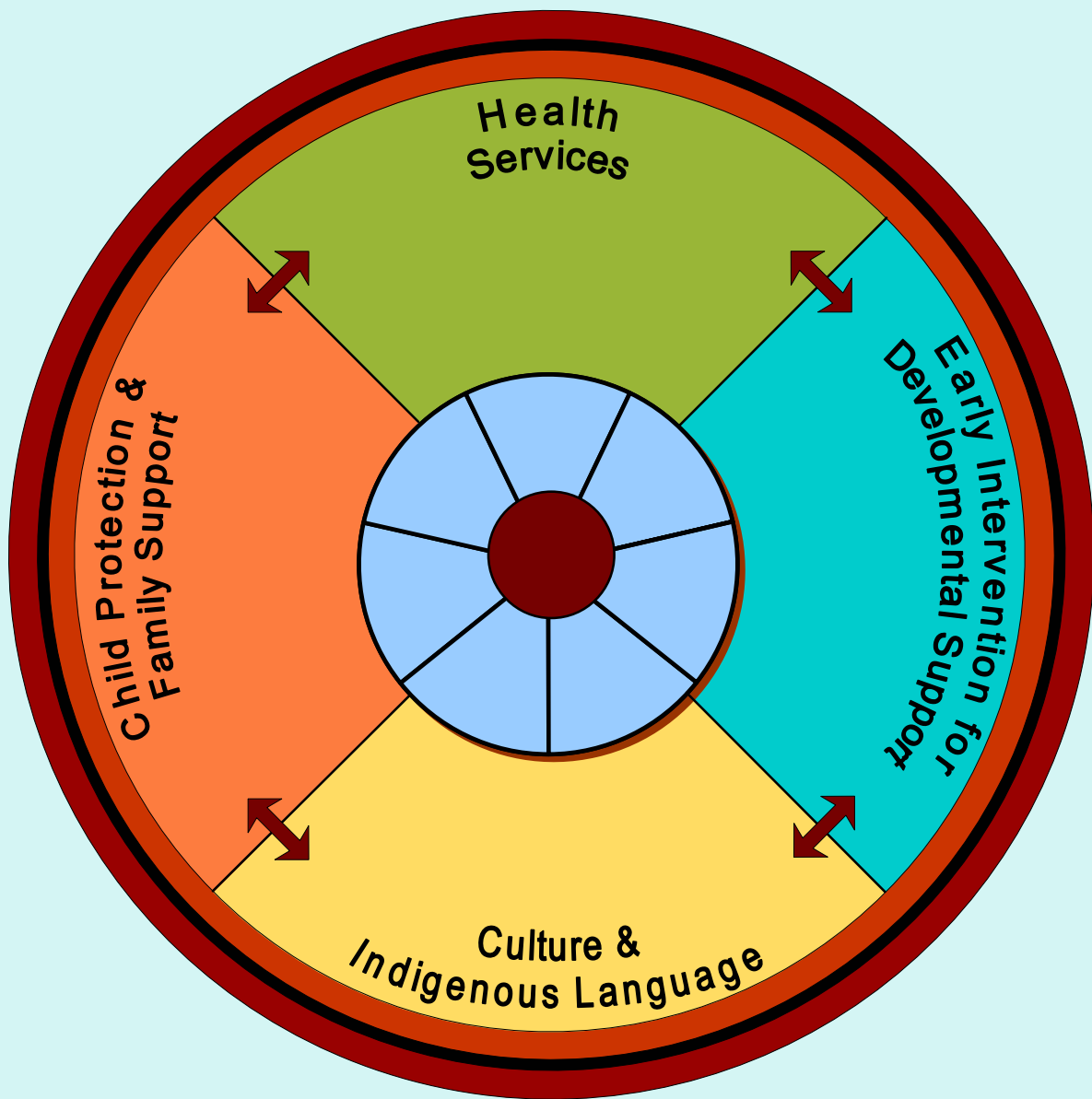


Capacity Development Model #2



Emergenc

Fully Integrated Intersectoral Model



Key findings in communities:

1. Holistic Service Delivery Model

- Child care is the site for multiple services, programs & visiting specialists – integration.
- Child care facility is the a primary site in the community for bringing people together, cultural events, information, education, social support, health fairs, health services, speech-language services, community kitchens. delivery.
- Bringing a child or grandchild for care ‘hooks’ a broad range of community members into a multidimensional, community-driven system of care.

“Our child care is a holistic model, and feels natural to us as Aboriginal people, where we have always seen children and the community as one. Children are the future of our community – they are, or they should be, in the centre of everything.”

- Mount Currie First Nation member -

Key findings in communities

2. Facilitating Professional Access to Small Communities

- ‘Fly-in’ professionals (dentist, optometrist, public health nurse)
- ECD as Hubs provide ready mutual access between community members & ‘fly-in’ professional services.
- Site for fly-ins to build relationships with a stable core of staff, become culturally literate, & follow-up large numbers attending regular programs.
- Site for community staff to learn from fly-ins, & take on some continuous service delivery (e.g., speech-language repetition, OT exercises, dental hygiene)
- Site for community staff to monitor services delivered to members, mediate, & explain services to parents.

Key findings in communities

3. Laddering of Services for Families & Children

- Child care can be an entry point (hook) for introducing parents to an array of information, support, & intervention
- Parents are comfortable first bringing child for care, and second receiving help for themselves
- Staff can monitor & identify developmental needs or periods of family stress & move diagnostic screening or extra supports quickly into place without high drama / disruption / costs /waiting time.
- Children at risk or designated in need of protection are more likely to be retained in community with laddered services readily available.

Key findings in communities

4. Stabilization of Community Services

- Gather & retain a qualified pool of professionals & para-professionals who become familiar with a variety of services across the intersectoral spectrum
- For children, when one staff leaves, a core of familiar, competent staff remain
- Child care for all community members promotes success in training & education & stable employment among adults

Key findings in communities

5. Capacity Development Through Ongoing Professional Support & Leadership Opportunities

- Mentorship, support networks & continuous cross-disciplinary, professional development
- Well suited to rural & remote communities where staff often feel huge burden of responsibility & social isolation.
- Cooperating staff provide back-up for travel to training events & for temporary leaves.
- Staff build shared body of procedural knowledge and knowledge of community members' growth, development & needs.
- Staff are inspired to further their education.
- As staff develop a holistic view of community needs & goals, they initiate new outreach & delivery programs.
- Leadership development - sustainable programs.

Impacts of ECD on child health & well-being

- “Whole-child” early intervention programs have most lasting impact on physical health & well-being. Long-term studies have found that children who participated in American Head Start have better health, immunization rates, & nutrition, as well as greater social and emotional stability than their peers who did not participate in the program.

- “Principles and Guidelines” of the Aboriginal Head Start Urban and Northern Initiatives, October 1998, p.4 -

Key principles for 'hub' model

- Hub: culturally vibrant child care
- Hook: involving parents & Elders in child care &/or cultural centre &/or community kitchen
- Holistic: child care, health & development, social, cultural, language programs
- Population-based: inclusive of all, not only high risk or low/high income.
- Strength-focused: Health promotion, wellness, information/education, cultural events.
- Community involvement all the way: planning, training, building, policy making, implementing, celebrating, evaluating

Challenges

- Enormity of need
- Specificity of conditions & goals in each community
- Jurisdictional ambiguities resulting in dominos – no ‘flower’ or ‘cloverleaf’ designs
- Excessively differentiated training pathways
- Segregation (& competition) of professional disciplines
- Fragmentation of political authorities perpetuating fragmentation concepts and models of what people need
- Passing the buck

More challenges

- Instability of funding & services
- Short-term funding (e.g., for ‘pilot’ projects)
- Mobility of populations
- Requirement of already developed capacity & extensive commitment of time in communities for planning, application, implementation, evaluation, accountability

Partnerships

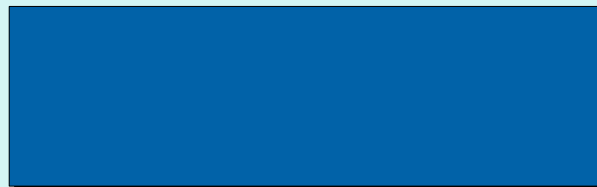
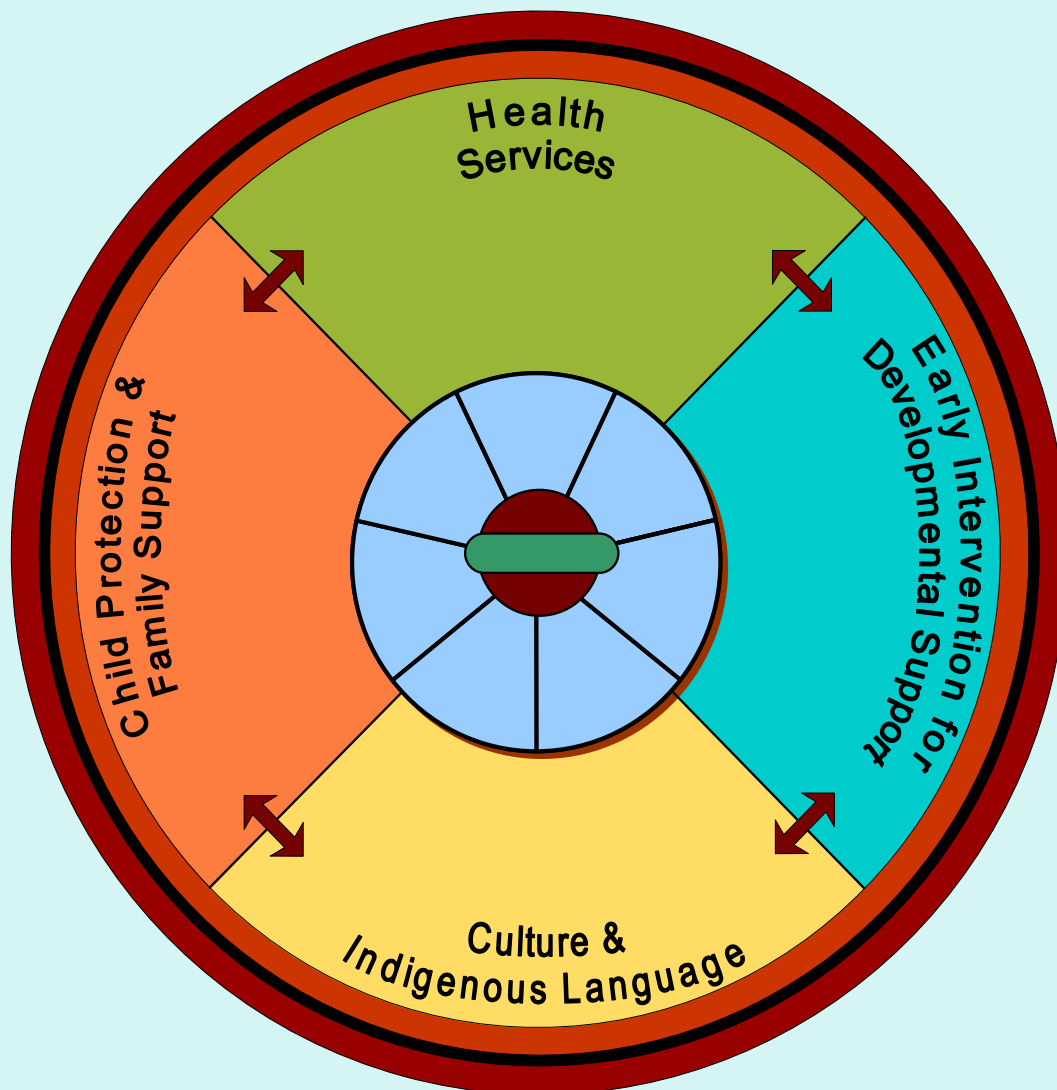
- Romanow: Aboriginal Health Partnerships
- Consolidation of funds across jurisdictions intended to streamline access to funding.
 - What about federal responsibilities to on-reserve residents, vs. provincial responsibilities to off-reserve?
- Collaboration but probably not consolidation
- Flexible, community-identified priorities & service delivery approaches.
 - How / what do communities chose?

Challenges

- Beyond ‘silos’ towards holistic concepts of well-being and multi-sectoral, integrated services:
 - Health, social services, housing, environment
 - What about education (early & post-secondary)?
- Funding for training generally fall under different jurisdiction than funding for services.
 - How can community capacity be built?
- Funding based on readiness:
 - Who’s ready? What if we’re not ready?
- Per capita funding.
 - But are needs equal?

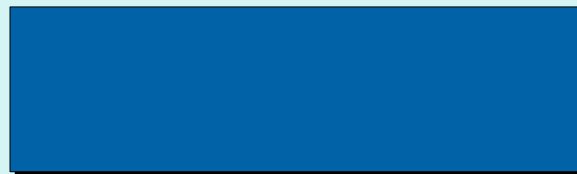
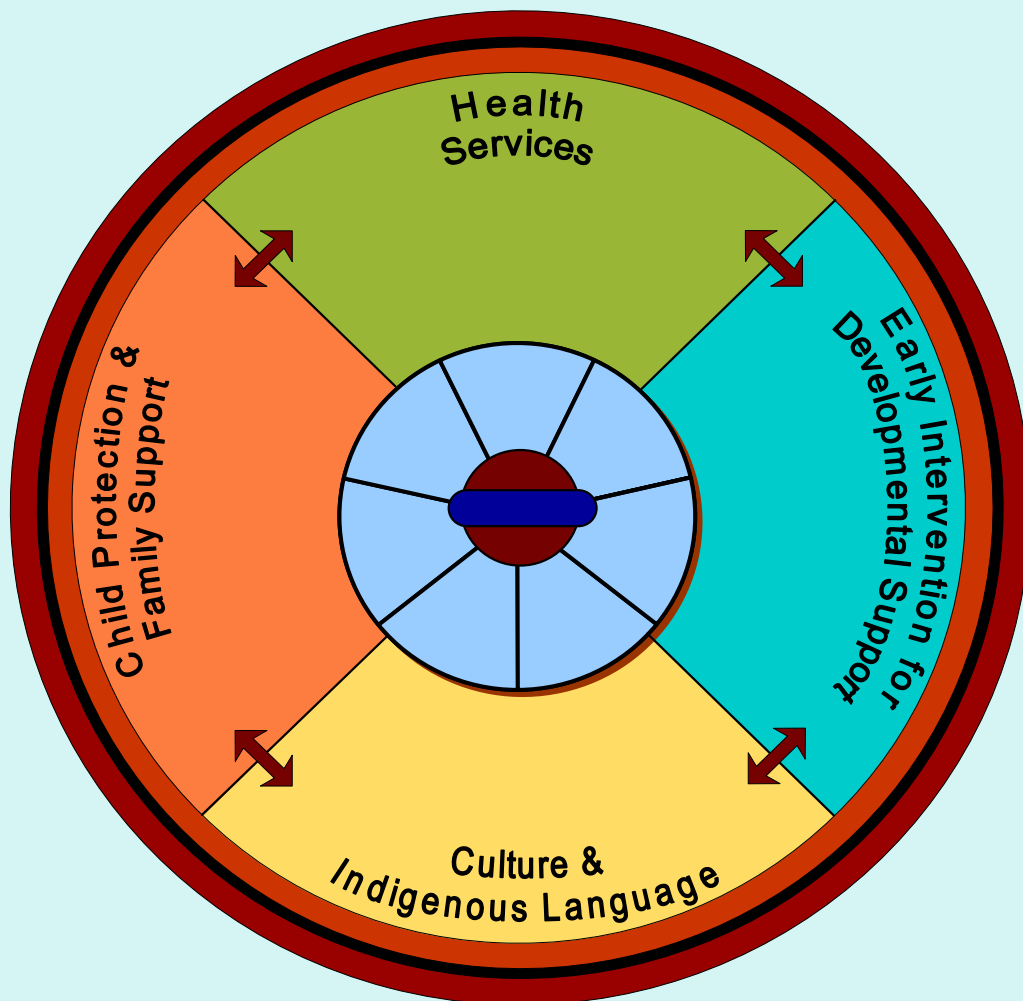
What is the 'centre'?

- Children are magnetic attractors, but are they the centre – conceptually, strategically, for evaluation of program impacts?



Family as the Centre

- Family centred practice is a preferred model in many Aboriginal communities
- Children are dependent upon functional families
- Families benefit from functional inter-sectoral services



Community as the Centre

- Elaboration of community-based inter-sectoral services with child care as hub relies on vision, cohesion, ingenuity, & health of a community

