

**Early childhood care and development programs as
'hook' and 'hub' for inter-sectoral service delivery in
First Nations communities¹**

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Abstract

Consistent with recommendations in the Royal Commission on Aboriginal Peoples, many Aboriginal communities are investing in early education, cultural transmission, and health for the youngest generation in order to secure the future well-being of their communities. A demographically young Aboriginal population, combined with a wish to support parents in pursuing education, employment, and healing, has led many communities to prioritize Early Childhood Care and Development programs.

This article reports findings of a research study of promising practices in three groups of rural First Nations that are evolving integrated service models centred around Early Childhood Care and Development programs as part of their community development approach. The findings suggest a conceptual model of Early Childhood Care and Development programs as a ‘hook’ for mobilizing community involvement in supporting young children and families, and as a ‘hub’ for meeting a range of service and social support needs of community members.

Child care and development programs in these communities include strong emphases on culture, socialization, English and heritage language proficiency, and nutrition. Co-location of child care with other services enables ready access to health monitoring and care, screening for special services, and early interventions. Once parents are involved in bringing a child to a community-centre based program, many are learning about and accessing programs for themselves and other family members. The

research showed how multi-purpose, community-based service centres can become a focal point for social cohesion and can provide a cultural frame around service utilization that informs external service providers and offers cultural safety for community members.

Key words:

First Nations

Aboriginal

Child development

Inter-sectoral services

Integrated services / Integration

Community wellness

Community-based service delivery

Child health

Early Childhood

Introduction

Promising innovations by First Nations communities in rural British Columbia are demonstrating the potential of Early Childhood Care and Development (ECCD) centres to serve as hubs for a range of programs and services that promote wellness, social cohesion, and cultural continuity. This article reports findings to date of a research study to: (a) document innovations in inter-sectoral service delivery in First Nations communities; and (b) in a later phase of the research, evaluate the impacts of innovations in community-based service delivery on First Nations children's health and development and on community wellness overall.

In all of the First Nations participating in the study, the creation of inter-sectoral service centres began with a long-term goal to strengthen community capacity to provide licensed, centre-based child care programs that would improve children's safety, development, and positive cultural identity. For each First Nation, the first step toward this goal was training. They each initiated a partnership with the University of Victoria to co-deliver a bicultural, community-based, university-accredited training program in Child and Youth Care to prepare community members to mount and operate the planned ECCD program. Concurrently, each First Nation raised funding and invested capital and human resources in the design and construction of a facility for their anticipated ECCD program. Subsequently, they mounted ECCD programs guided by explicit, community-derived goals of supporting the development of 'the whole child' and of keeping the family, community, and cultural ecologies of children clearly in focus.

What has now evolved from these foundations varies across communities as a result of their specific goals, resources, and geographic circumstances. In each case, there are lessons that can be learned about overcoming the challenges of working across jurisdictions, professional ‘turfs’, and regulatory spheres, and principles to inspire explorations by other Indigenous and non-Indigenous communities about the real possibilities for mounting comprehensive, accessible, developmental support systems for children and families.

Aboriginal ways

Our initial assumptions about health and wellness profoundly influence how we design, implement, and evaluate systems of supports for health and development. Rich and diverse philosophical systems for understanding the nature and purpose of human life and how best to support it reside within Indigenous communities in Canada (e.g., see Battiste, 2000; Long & Dickason, 1996; Stephenson, Elliott, Foster, & Harris, 1995). These knowledge systems are beginning to find their way into discussions about how to move forward to improve the health and wellness of Indigenous people.

In British Columbia, there is a major transition underway with 82% of eligible First Nations assuming control over some or all of the community health, primary health, and children’s services for their members. With this shift, chronic unmet needs for training of Indigenous people in health and human services have become acute. In provincial and regional meetings of Indigenous leaders about ways to strengthen the capacity of their communities to mount and operate new services or to take over existing services, a point repeatedly heard is that Indigenous people want to learn from the mistakes of non-Indigenous people. They do not want to replicate the fragmentation and

some of the inefficiencies of mainstream health care in Canada. A representative of one of the regional inter-tribal health authorities in British Columbia put it this way: *“Yes, we need training. But what do we want to train our people to do and to become? The transition to Aboriginal control should not mean simply Aboriginal people taking over White jobs, doing things in White ways. We want to do things in Aboriginal ways, and we need training that will support our members in remembering their cultures and creating Aboriginal services that are really Aboriginal.”*

Aboriginal ways as an original ‘population health’ conceptual framework.

The First Nations participating in the current research and earlier training partnerships with the University of Victoria each engaged in two years of community-wide discussions about the meanings of child and family wellness within the culture and lifestyles of their own people. Across all the communities, the themes of holism, ecological contextualism, and community-embeddedness were heard again and again. Indeed, it would seem that Indigenous ideas about how to support the survival, healthy growth and optimal development of Indigenous peoples have long embodied the assumptions, aims, and approaches that we are now calling ‘population health.’ From the point of view of this author, who is of Irish and English ancestry, there is much that non-Indigenous as well as Indigenous people can learn from exploring the possibilities inherent in Indigenous ways of caring for health.

Holism. In these First Nations, child development is viewed holistically, with the many aspects of a child’s body, mind, and spirit seen as intertwined and requiring nurturance, guidance, and respect. This view permeates community decisions about what child care and development programs should entail; namely, a proactive, developmental

approach to the ‘whole child’ that included nutrition, preventive health, socialization, education, Indigenous language and culture.

Ecological contextualism. The goal of improved community conditions for children’s health and development in these First Nations was seen as dependent upon the goal of supporting family wellness. Thus it was conceived that child care and development programs should include extensive outreach to secure the active involvement of parents and others who care for children. As a child care practitioner in one of the communities said: *“When a child comes back [to our centre] on Monday morning, we can usually tell how the parents are doing, and what’s been happening over the weekend.”* Thus a goal of the child care and development strategies in these communities has been to provide a culturally safe (i.e., free of racism and culturally respectful), socially supportive centre for parents to be consulted about their child and offered opportunities to participate in the child care program, parent education and support programs, and service referrals as needed.

Community-specificity, not ‘best practices.’ Effective population health strategies are not uniform; rather, they are based on geographically, politically, and culturally situated understandings of what health is and how to achieve it in particular populations. Given the enormous diversity among First Nations, the author rejects the notion of ‘best practices.’ The concept itself is reminiscent of modernist ideals of ‘truth’ and ‘one size fits all’ approaches to community development and population health. These notions are antithetical to understandings of health as multiply determined and variable depending upon the population and setting. The language of ‘best practices’ is foreign to an ecoculturally situated understanding of community wellness that recognizes

the ethics and efficacy of grounding programs to support wellness within the Indigenous knowledge, cultural concepts, socialization practices, needs and goals of a community.

Further, the concept of population health should not be misconstrued as promoting universal application of the same program objectives, models, and evaluation criteria for all people everywhere, as has sometimes been implied. On the contrary, population health initiatives need to be based on an intimate knowledge, not only of the demographics, but of the social conditions, circumstances, resources, and readiness of groups within the fabric of society as a whole who define themselves or can be defined as a distinct population. Thus, support for targeted programs such as Aboriginal Head Start for Aboriginal children and for hot meals programs for malnourished children are consistent with a population health framework.

The First Nations who participated in the current research understood this implicitly. They rejected a ‘one size fits all’ approach to training and the possibility of any imported ‘best practice’ model that would be suitable for adoption in their communities. Instead, they sought training and design child care programs that would draw upon Indigenous knowledge retained by their Elders and other community members, and that would address the specific needs, circumstances, and goals of children and families in their communities.

To avoid conveying a false impression that these ideas were all explicitly articulated before the participating First Nations embarked on their journeys through training and service implementation, it must be said that these guiding principles were only gleams in the eyes of a few community members, most conspicuously Elders, when the training programs began. Their ideas about combining and co-located services with

their child-care programs were explored and debated, and were finally quite clearly articulated by the end of two years of community-based training in ECCD. (The nature of this innovative approach to strengthening capacity in communities will be described subsequently.)

Throughout the two years of capacity building, community members worked to recover, uncover, and construct understandings of child and family care and development that: (a) fit well to describe their communities; (b) worked to explain the current health status and conditions for development of their children; and (c) yielded insights into what needed to be done to innovate ‘promising practices’ for achieving community-identified goals for improved health and well-being for all of the children in their communities. These ideas provided the conceptual foundation for subsequent development of community-based services which are described in this article as ‘promising practices.’

Conceptual propositions. To summarize, the program of research on ECCD as a hub for inter-sectoral service delivery rests on three postulates: (1) the first posits that services appropriate to Indigenous people should probably be based on conceptualizations of child and family wellness as holistic, ecologically contextualized, and embedded within specific community development and health needs, goals, and cultural knowledge; (2) the second posits that training and services must recognize the socio-historical experiences that have negatively pre-disposed many Indigenous people towards formal health, social and education services and certain cultural, financial and geographic factors that increase the likelihood of success of integrated, community-based service delivery with families as a whole; and (3) the third posits that Indigenous

communities must be the drivers of initiatives to improve Indigenous population health and well-being.

The goal of ‘Inter-sectoral Service Delivery’

In 2002, the Romanow Commission was appointed by the federal government of Canada to provide a status report on health care in Canada and to offer direction for the future of health care (Romanow, 2002). As noted by the former national Chief of the Assembly of First Nations, Mathew Coon Come, the Romanow Report was the first national report ever to devote specific attention to Aboriginal health. The Romanow Commission concluded that the state of health and well-being, and the conditions of life for Aboriginal people in Canada, is inexcusably low and must be addressed.

Inter-sectoral service delivery was strongly recommended by the Romanow Commission, particularly for improving the health of Aboriginal people and Canadians residing in rural and remote settings. In its report, the National Aboriginal Health Organization is quoted as submitting to the Commission that: “...*one of the essential ingredients in creating effective Aboriginal health systems is a multi-jurisdictional approach to health service reform*” (p. 224).

Key recommendations of the Romanow Commission for improving the health of Aboriginal peoples include:

- Consolidate Aboriginal health funding from all sources and use the funds to support the creation of Aboriginal Health Partnerships to manage and organize health services for Aboriginal peoples and promote Aboriginal health.
- Establish a clear structure and mandate for Aboriginal Health Partnerships to use the funding to address the specific health needs of their populations, improve access

to all levels of health care services, recruit new Aboriginal health care providers, and increase training for non-Aboriginal health care providers.

- Ensure ongoing input from Aboriginal peoples into the direction and design of health care services in their communities.

Key recommendations of the Romanow Commission for improving the health of rural and remote populations similarly emphasize inter-jurisdictional coordination and pooled resources, including:

- Establish a new Rural and Remote Access Fund to support new approaches for delivering health care services and improve the health of people in rural and remote communities.

While the philosophical and practical rationale for breaking down jurisdictional silos and coordinating training and service efforts may be a recent illumination here in Canada, there is a voluminous international literature advocating ‘inter-sectoral’ and ‘integrated’ service delivery for promoting maternal and child health, growth and development (e.g., Haddad, 2001; UNICEF, 2001; Woodhead, 1996). Unfortunately, the international literature on inspiring examples in practice is much more attenuated (O’Gara, Lusk, Canahuati, Yablick, & Huffman, 1999). Chronic disappointments in moving forward on the inter-sectoral agenda in Canada and abroad can be attributed to a number of political, conceptual, and practical barriers, including:

- the hegemony of European-heritage worldviews and forms of governance;
- reluctance to share authority over health care expenditures and accountability for health outcomes with communities;
- anachronistic, fragmented bureaucracies;

- competing theories about the determinants of health;
- a persistent emphasis in health theory, research, and practice on the individual as the unit of analysis;
- a reliance upon physicalistic interpretations of health status and health care;
- professional turfism.

With reference to British Columbia, de Leeuw, Fiske, and Greenwood (2002) concluded that the fragmented system of social, health, and education services is the most significant barrier to population health in rural, northern, and First Nations communities.

Given these substantial challenges, the innovative approaches of the First Nations participating in the current research are particularly worthy of examination.

‘Children are our Future’: Early Childhood as a ‘Hook’ for Community Mobilization

There are strong arguments to give priority to ECCD as a population health initiative. In many First Nations, the reason is simply and frequently stated: ‘*Children are our future.*’ The Meadow Lake Tribal Council in Saskatchewan, who co-developed the community-based training program in Child and Youth Care with the University of Victoria², gave the following account: “*The First Nations of the Meadow Lake Tribal*

² This bicultural, community-based, university accredited training program in Child and Youth Care was conceived in 1989 in a partnership between the Meadow Lake Tribal Council in Saskatchewan and the School of Child and Youth Care at the University of Victoria. The initiating leader at MLTC was Ray Ahenahew, and the founding coordinator at UVic was Alan Pence. The author is currently the coordinator

Council believe that a child care program developed, administered, and operated by their own people is a vital component of their vision of sustainable growth and development. It impacts every sector of their long-term plans as they prepare to enter the twenty-first century. It will be children who inherit the struggle to retain and enhance the people's culture, language and history; who continue the quest for economic progress for a better quality of life; and who move forward with a strengthened resolve to play their own destiny.” (Meadow Lake Tribal Council Vision Statement, 1989).

Increasing numbers of First Nations in Canada identify ECCD training and services as priorities within a comprehensive vision of community development, population health, and economic advancement. ECCD is seen as essential for protecting and enhancing the physical and psycho-social health and well-being of Indigenous children and their families. This need is particularly urgent for First Nations living on reserve, where access to children's programs and family supports is limited by geographic distances, social and cultural barriers, and eligibility regulations. The Assembly of First Nations in Canada has long urged that caregivers be trained to deal in a culturally appropriate manner with the large pool of First Nations children needing comprehensive care (Assembly of First Nations, 1989). Similarly, in British Columbia, an Aboriginal Committee Report on Family and Children's Services Legislation in 1992 stated that: *“Our main goals are to preserve and strengthen our culture; to support and maintain the extended family system; to promote the healthy growth and development of*

of this program, called the First Nations Partnerships Program, at UVic. For more information, see www.fnpp.org or contact the First Nations Liaison: Onowa McIvor at fnpp@uvic.ca.

our children and to develop community-based programs conducive to the realization of these goals” (Aboriginal Committee, Community Panel, 1992, 9).

Aboriginal Demographics

The demographic characteristics of Indigenous people in Canada provide another reason to focus population health strategies on Indigenous children and youth in a bid to improve the overall life expectancies, health status, and developmental chances of Indigenous people in Canada. Among 700,000 First Nations and 50,000 Inuit in Canada reported by Statistics Canada in 1998, the average age was 25.5 years, which is 10 years younger than the average age of all Canadians. The proportion of First Nations and Inuit people under five years of age is 70% greater than for the population as a whole. First Nations and Inuit populations are expected to grow at double the rate for the general population. The First Nations and Inuit Health Branch reports that, as of 1998, there were 54,225 First Nations and Inuit children in Canada under four years of age (FNIHB, 1999). In British Columbia, as of 2001, there were 9,573 First Nations and Inuit children under four years of age (Vital Statistics, Province of British Columbia, 2001). Although the national birth rate for First Nations fell between 1979 and 1999, it remained twice the national average. Of First Nations women giving birth, 58% were under 25 years of age, with 23.7% being 15 to 19 years of age. As of 1999, almost one third (32%) of Aboriginal children under the age of 15 years lived in a single parent family (FNIHB, 1999).

In British Columbia, although recently reported health data show that Aboriginal health is improving alongside improvements in the health of all British Columbians (Province of B.C., 2001), significant gaps between Aboriginal and non-Aboriginal health

and well-being remain. Aboriginal children are over-represented on nearly every indicator of health, social, and education risk. Fifty-two percent of Aboriginal children in B.C. live below the poverty line. Aboriginal children are 7 times more likely than non-Aboriginal children to be in government care: 40-50% of children apprehended for child protection and placed in out-of-home care are Aboriginal.

A more conservative, and more frequent, argument for increased support for ECCD is that it enables more women's participation in the labour force. Indeed, the barrier First Nations parents most often cite that prevents them from obtaining or holding employment, completing their education, or undertaking employment training is the absence of child care. While child care cannot resolve the multiple reasons for low levels of employment among First Nations, child care is generally considered a foundation of labour force attachment. In 1995, the Canadian minister of Foreign Affairs made this argument in address to the Assembly of First Nations Forum on Child Care: *"We can't help deal with the early development needs of children and we can't respond to what is going on in the economy unless we have in this country an effective child care system."* (Axworthy, cited in Greenwood, 1998).

Research over the past 15 years has confirmed what many parents and development specialists have long known; that good health, stimulation, and nurturance in infancy and early childhood are critical determinants of survival, growth, and development throughout the lifespan (e.g., Shonkoff & Phillips, 2000). The early years of a child's life are important across many domains of development, including physical growth, motor coordination, emotional health, social competence, cognitive processing, language and pre-literacy skills. The seeds of cultural and ethnic identity are also sewn in

these early years (Rogoff, Mosier, Mistry, & Goncu, 1998). Infants and toddlers are dependent upon social belonging and relationships for survival, formation of a sense of self, ability to form attachments to others and capacity to engage in trusting, affectionate relationships characterized by empathy and reciprocity (Super & Harkness, 1998). It is in these early years that a child begins to learn what it is to belong to a social group, and absorbs many of the mannerisms, ways of life, values, and forms of interaction that are hallmarks of their culture of origin (Kantor, Elgas, & Fernie, 1998).

The First Nations participants in the current research saw that ECCD could play a central role in their consolidation as stable, healthy, cohesive and culturally robust Indigenous societies within the larger ecologies of life in Canada. When community leaders held forums for their members to discuss the idea of making ECCD a focal point of community capacity building and infrastructural development, the value of assuring quality care for babies and preschoolers was an easy ‘hook’ for mobilizing positive community action.

Aboriginal Child Care Strategy in Canada

Jurisdiction, and therefore funding and service for Aboriginal child care in Canada, is caught between federal responsibility for reserves and provincial jurisdiction for health and social services (Greenwood and Shawana, 2000). At the same time, each province has its own distinct policies governing child care programs, and has unique relationships with First Nations. In practical terms, this has meant that until 1995, First Nations communities on reserves in Canada had no access to child care funds, there was no strategic plan, and there were few ECCD services (Greenwood et al., 2000; B.C. Child Care Resource and Research Unit, 1997).

In 1988 the federal government provided funds for the development of pilot projects to address First Nations and Inuit needs for child care. In 1989, a *Report of the National Inquiry into First Nations Child Care* was published, outlining the need for an Aboriginal child care strategy (Greenwood et al., 2002). In 1995, the Assembly of First Nations hosted a National Forum on Child Care. This was followed in the same year by the introduction of the First Nations and Inuit Child Care Program and the Urban and Northern Aboriginal Head Start program for First Nations living off reserve. Aboriginal Head Start was established to help enhance child development and school readiness of Indigenous children living in urban centres and large northern communities. By 2000, 168 Aboriginal Head Start programs were operating in 300 off-reserve communities, serving approximately 7,000 children up to the age of 6 years. In 1998, the Aboriginal Head Start program was announced for children and families residing on reserve.

Regulation and licensing of child care centres varies widely from province to province, including whether each provincial government regulates child care services on reserves. In 1999, a legal decision was taken that the Province of British Columbia could exercise provincial regulations on reserves, by invitation of First Nations communities. This meant that child care facilities, whether on or off reserve, could opt to be licensed according to provincial standards, and would then be eligible for certain funding and other resource supports. At the same time, the federally funded Aboriginal Child Care Society of British Columbia began working toward a framework for appropriate Aboriginal standards.

One outcome of recent changes is that, whereas 20 years ago there were virtually no licensed child care programs on reserve, there are now licensed child care programs

and also Aboriginal Head Start programs. In British Columbia, both programs are now eligible for operating grants, one from the province and the other from Aboriginal Head Start. The two programs have separate training requirements, with Aboriginal Head Start offering an in-house cultural training program with basic professional development in nutrition and early childhood stimulation. Child care staff in licensed facilities on reserve must include one certified Early Childhood Educator.

In 2002, the Government of Canada and provincial and territorial governments (with the exception of the Government of Quebec, which instituted universal child care in 1998) reached an agreement to improve and expand the services and programs they provide for children under six years of age and their families. The Federal/Provincial/Territorial Early Childhood Development Agreement is a long-term commitment to help young children reach their full potential, and to help families and the communities in which they live to support their children (Government of Canada, 2002a). The Government of Canada announced that it will invest an additional \$320 million over the next five years to support and enhance the early childhood development of Aboriginal children. This new funding will be used to enhance programs such as Aboriginal Head Start and the First Nations and Inuit Child Care Initiative. It will also be used to support research on the health and developmental status of Aboriginal children and factors accounting for these developmental outcomes (Government of Canada, 2002b).

Challenges in Rural and Remote Communities

Particular kinds of challenges face small, rural, and geographically isolated communities. The Romanow Commission report on *The Future of Health Care in Canada* (2002) devotes a chapter to health issues in rural Canada, noting that rural

populations are under-served, at risk of poorer health, and in need of innovative models of health promotion and service delivery. The First Nations and Inuit population in Canada is spread over 800 communities (605 registered First Nations), with 77% of these comprised of less than 1000 people. Transport models of health care and specialized services for children are costly in terms of lost wages, travel and accommodation expenses, family disruptions affecting continuity of care for children, and discontinuity in the roles that adults play in maintaining their community. Models of child and family support and health care that may be acceptable or effective in urban centres in Canada are frequently not acceptable or effective in rural and remote circumstances, especially when these are compounded with significant cultural and lifestyle differences.

In British Columbia, a Report of the Northern and Rural Health Task Force (1995) underscored challenges specific to rural settings, adding to the list: lack of qualified personnel; difficulties retaining qualified personnel; the tendency for government bureaucracies and professionals to plan health services for Aboriginal people without seeking their early and complete involvement; gaps and confusing overlaps in service provision because of overlapping federal and provincial jurisdiction; the arbitrary nature of provincial health region boundaries which often do not appropriately reflect tribal boundaries; and the need to recognize and respect Aboriginal traditions in health promotion and care.

Need for an ecological conceptual framework for population health. In a study exploring ways to reduce risks to rural and northern children and youth due to substance abuse, De Leeuw, Fiske, and Greenwood (2002) noted that: “*When, as is*

currently the case, the overwhelming focus on special needs children is on one condition [substance abuse], northern and remote communities find it difficult if not impossible to address the full range of service needs. ...Currently, child welfare policies, women's programs and health initiatives fail to offer comprehensive approaches to meeting the unique needs of the communities" (p. 13).

It is interesting to note that similar difficulties have been reported from the perspective of population health issues facing Aboriginal peoples in Australia: (O'Donoghue, 1998, p. 65): *"Medical mysteries are relatively rare. The current patterns of Aboriginal morbidity and mortality can be explained...individual health can be profiled against key indicators such as diet, level of education, financial comfort, adequate housing, unpolluted environment and access to a range of goods and services. In Western societies this means that the richer you are, the more educated you are, the healthier you are likely to be. This stark reality is not good news for Aboriginal people whose education participation is low and for whom wealth isn't a likely possibility.... we need a model that acknowledges the cultural, social and emotional dimensions that impact on sickness and health. When we talk about health for any society, we must adopt the broadest possible definition. One that considers communities as well as individuals... and... environmental health issues like sanitation, adequate sewerage systems, a clean water supply and adequate housing."*

The key message of the Romanow Commission in reference to rural and remote communities is to move toward a population health approach characterized by pooled funding and coordinated actions across jurisdictions. A broad scope of goals include improving environmental conditions to lead to health, such as adequate housing, assured

supplies of clean water and fresh food, and recreation, in addition to primary health services. **The recommendations of the Romanow Commission provide strong support for initiatives that place child care and development of a community's children at the hub of a coordinated, inter-sectoral system of programs and services for children, families, and the community as whole.**

Program of Research: Follow-Up Case Studies

First Nations demonstration sites.

As described earlier, three First Nations are currently partnered with the author in a program of research to document and evaluate community-driven innovations in ECCD. Members of these First Nations completed two years of diploma-level course work in Child and Youth Care. Their goal was to advance community development by improving conditions for young children and their families. In a series of steps conceived as a post-secondary education and career ladder, students enrolled in this partnership program become eligible for certification by the Ministry of Health in British Columbia in: Caring for Children (Basic certification); Caring for Infants and Toddlers (Post-Basic Certification I); and Caring for Children with Special Needs (Post-Basic Certification II). All of the courses involve Elders and other community resource people instruction, dialogue, and learning, using a 'community of learners' approach. The curriculum is bicultural, with Indigenous as well as European-heritage knowledge and practice co-considered by community members (Pence & Ball, 1999). In each community, this process has generated community-specific, culturally grounded knowledge and ideas for moving forward with actions to support child well-being (Ball & Pence, 1999; Ball, Leo, & Pierre, 2000).

Evaluation research showing the unique success of this partnership program with seven other groups of First Nations has been reported elsewhere (Ball & Pence, 2000; Ball & Pence, 2001). Previous research showed that this program was more successful than any other post-secondary program in Canada in terms of: Indigenous student completion rates; community-involvement in training; incorporation of Indigenous knowledge; revitalization of intergenerational teaching and learning; and retention of graduates in employment in their communities (Ball, 2002).

Table 1 shows the community capacity built in the training partnerships involving the three First Nations in the current program of follow-up research. Across the three groups of communities: 40 community members enrolled in the program; 36 (90%) students completed the two years of full-time course work; 30 (75%) of the original enrollees are currently working in a human service capacity; and 25 (63%) of the original enrollees are employed specifically in the area of ECCD in their communities.

Community Members	Community 1	Community 2	Community 3
Students enrolled	10	15	15
Students completed	8	14	14
Graduates working (part time or full time)	8	10	12
Graduates working in ECCD	8	7	10

Table 1. Community capacity resulting from community-university training partnerships in Child and Youth Care

All three First Nations that initiated and co-delivered the training partnerships have now developed community-based ECCD programs. Over time, these ECCD programs have evolved to: (a) deliver services that are new in the community; (b) encompass services traditionally fragmented in other locations in the community, using different funding sources, facilities, and personnel; and (c) ‘bring home’ services that had previously been located at some distance, often very far, beyond the community.

These three sites each offer insight into successful models of service delivery in communities ranging in size from 120 to 1800 members.

Method

Commencing in 2002, a program of research was initiated by the author, in collaboration with three groups of First Nations partner communities, with the following objectives: (a) to document the evolution and elaboration of ECCD initiatives in First Nation communities located on reserves; (b) to examine community-level determinants of sustainable ECCD programs that are perceived by community members as meeting the needs of children and families; and (c) to assess the impacts of community-led ECCD initiatives on child development outcomes.

For the First Nation partner communities, the goal of this research is to contribute to knowledge among Indigenous leaders about effective principles and practices for: (a) engaging in partnerships with external organization such as universities, service agencies, and funding bodies; (b) ensuring that training and service delivery enhances rather than depletes cultural continuity and self-governance in communities; and (c) achieving a coordinated strategy for supporting the health and development of Indigenous children.

For the author, the goal of this research was to add to conceptual understandings about the potential for positively influencing the health and development of Indigenous children through training and funding strategies that strengthen Indigenous community capacity to deliver ECCD. Another goal is to identify ways in which institutions and individuals outside of First Nations can support and serve as allies to First Nations as communities develop capacity and move forward with their community development strategies. Finally, a goal of the research is to provide a context for mentoring Indigenous researchers.³ Thus, the three First Nations and the author have embarked on a multi-method, multi-component program of research to document, evaluate, feedback to community members, and disseminate information about their explorations in ECCD as a ‘hook’ and ‘hub’ for promoting population health.

This program of research is in its early stages and details of the various data collection methods and findings on specific themes will be reported at a later stage. Early findings, reported in this article, are derived from a series of group forums and individual interviews with a broad range of community members and external service professionals involved in the ECCD programs operating in each of the communities. Using a social participatory approach, questions for these forums and interviews have been developed collaboratively with community-based research collaborators. The focus has been on community members’ definitions of child health and development; their perceptions of the determinants of child health and development; their evaluation of the efficacy of their community’s approach to supporting child health and development; their own experiences with ECCD and related social service programs; and their recommendations for sustaining and improving child health and development in their community.

³ If interested, please contact the author: jball@uvic.ca

Collaborative information gathering to date has focused on: (a) what each community is currently doing as part of its child care and development strategy; (b) how these initiatives articulate (or do not) with one another; (c) how they are funded; (d) the logistics of administration and accountability; and similar information to complete a rich description of each community's emergent conceptual model for implementing population health strategies targeted at young children. The stage reached at the time of current writing has yielded detailed portrayals of the use of ECCD as a hub for inter-sectoral service delivery. A synopsis of these findings, focusing especially on one community, will be provided subsequently.

FINDINGS: Three models in communities using ECCD as hub

Community 1: Integrated Services.

Community 1, located on a Carrier-Sekani reserve in North Central British Columbia, received funding in 1996 for construction of a child care facility in a wing of the public school located on reserve. A condition of funding for construction was that the community would also mount a training program to prepare community members to operate the child care program. The training program was completed at nearly the same time as the child care facility was completed, and the cohort of graduates immediately mounted a centre-based child care and development program. Shortly thereafter, the community received funding for Aboriginal Head Start. This enabled an expansion in the numbers of children served. Both the child care and the Aboriginal Head Start programs are wholly run by community members. Both have received excellent evaluations from the regional child care licensing officer and an Health Canada Aboriginal Head Start Evaluation team.

Inter-sectoral service delivery occurs through the integration of health promotion programs on-site in the child care centre and Aboriginal Head Start program. These include: nutritious meals, preventive dental care, primary health care, including immunization, vision, hearing and speech screening, and specialist services such as supported child care for children with Fetal Alcohol Spectrum Disorder, and speech-language therapy. In addition, children who may have been identified by the regional child protection worker as requiring protective intervention may be required to attend the child care program where they can be kept safe during the day and their well-being can be monitored. This is reducing the number of children placed in foster care away from the community.

Community 2: Pooled Resources.

Located in Northeast British Columbia, this research partner is actually a coalition of six culturally distinct First Nations ranging in size from 120 to 600 members. These on-reserve communities joined together to mount the funding, hire the instructors, and share facilities for the two-year training program in Child and Youth Care. Each community selected three community members to undertake the training, which was delivered in the largest community, in partnership with the University of Victoria. Not all of the communities have yet been able to mount their own ECCD program. However they are pooling funding from various sources and sharing resources. One community received funding to start an Aboriginal Head Start program, which was conceived as a Cree language immersion program. Cultural transmission is a top priority in this ECCD initiative, while school readiness is a close second priority. With only 120 community

members, additional services delivered from this site are possible because of pooled funding and service agreements with neighbouring First Nations.

Each community in this group of First Nations has its own Community Health Representative. They all share a family support worker, a Wellness worker, and a Public Health Nurse. Travelling specialists such as speech-language therapists and consultants from the child development centre in the nearest town are conveniently able to meet and monitor children attending the Aboriginal Head Start program, consult with parents, and provide specialized support services as needed. The Aboriginal Head Start has thus become a hub for inter-sectoral service delivery to improve supports to a dispersed rural, population of Indigenous children and families.

Community 3. ECCD as hub in an inter-sectoral service multiplex.

Community 3 is part of the group of First Nations called the Stl'atl'imx Nations, whose traditional territory spans a large mountainous region in south-western British Columbia. The population centre of Community 3 consists of about 1400 members, which is mid-sized among First Nations communities in rural areas in Canada. Several First Nations and other small communities are in valleys radiating out from the community, so that it serves as a hub for much smaller communities.

Difficult winter driving conditions means that although the community is only three hours drive from a metropolis, it meets Health Canada criteria for definition as semi-isolated. Residents identify it as semi-isolated, noting transportation as a major barrier to accessing both routine and occasional services. There is little traffic through the community. An emergency health clinic is 20 minutes from the reserve. The first

hospital beds are one hour away, located in a small health clinic. The maternity clinic is one and one half hours drive away

Child and youth care training.

This community initiated a partnership with the author, based at the University of Victoria, School of Child and Youth Care, in 1997. This community was unique among the First Nations partners with the University of Victoria, in that there were enough qualified community members to meet university criteria for instructing in the training program so that the community did not need to recruit externally.

As part of a comprehensive child care strategy, the community mounted the training program at the same time that they broke new ground for the construction of a child care facility. The child care facility was conceptualized architecturally as part of a ‘multi-plex’ that has grown over time. It now houses an infant and toddler care centre, a child care centre for preschool aged children, indoor and outdoor after-school care facilities, a cultural centre, health centre, social service centre, administration offices, community kitchen, and community gathering space.

In May, 1999, fourteen of the fifteen community members who enrolled in the diploma training program were honoured in a community graduation ceremony that drew a crowd of several hundred community members. On the following day, the community celebrated the grand opening of the multiplex, and the centre and the ECCD programs housed there were given Indigenous language names by which they are known. The new generation of graduates forms the foundation for services for the community’s young children.

As part of the training program, students had undertaken community consultations to plan the desired elements of the infant, toddler, and preschool programs they would initiate, ensuring that the program was designed with the involvement and explicit needs of community members in clearly in focus. They had also developed manual of child care policies and procedures, and had learned the rudiments of administration of child care facilities and community development. Thus, within weeks of graduating from the training program, the community was ready to enrol children for the child care programs, which were soon fully subscribed. Many more children in the community have been turned away from the service due to insufficient spaces.

Culture.

A cohesive group of Elders, most of whom are fluent in their Indigenous language, actively support the ECCD staff. Intergenerational relationships are particularly easy here since many Elders played substantial roles in the ECCD training program. Staff work hard to bring many cultural activities, such as drumming, dancing, singing, and speaking their Indigenous language, into the daily curriculum. They also involve children in seasonal activities when they learn the skills that have traditionally provided sustenance for this community, such as smoking and drying fish, berry picking, and basket making. The children also receive advance preparation to take part in community festivals and other events throughout the year.

Culture is transmitted in less visible ways as well. At the child care centre, children come to know to their relatives and they develop relationships with this extended family. Elders, staff, and parents explained that “being proud of who you are” is important, and that this process can begin in their community child care program where

children are learning about themselves, their heritage and their community, starting with their own relations.⁴ Also, several staff and parents identified children's opportunity to develop 'healthy socialization' as one important outcome of having children cared for in a group setting composed of their own community members. For example, child were learning to take turns, wait for others, help others, and play with other children with whom they will share in community life for years to come.

Indigenous language.

Parents reported that they were proud of the cultural knowledge and pride that their children were learning. Many parents said that they were learning from their children many words and songs in their Indigenous language.

Parent involvement.

In this particular First Nation, a majority of parents bring their children to the centre for care because they are working or continuing their education on a full time basis. A small number are using the time while their child is at the centre to pursue their own healing, such as substance abuse treatment programs and other rehabilitation and support programs. As a result of, there is a low level of parent involvement in the ECCD programs. However, there is a high degree of 'attachment' of parents to various programs and services offered at the multiplex. For example, over 60 parents of children enrolled in the child care program have participated in one or more early language facilitation programs for parents, offered by a registered speech-language pathologist seconded to the community from the regional Children and Family Development office. Many parents have participated in Best Babies programs and other parent education and

⁴ The importance of 'knowing who you are' was documented by Harris (1995) as a theme in the stories of another First Nation about wellness.

support programs. They have been exposed to health information displayed on bulletin boards and resource tables situated at the entrance to the multiplex.

Nutrition.

The multiplex has a kitchen for community meals, and snacks are prepared for children attending the preschool and the infant and toddler programs. Children bring their own lunch. Observing that a few children lack nutritious foods from home, a funded nutritious meal program is a component that staff are hoping to add in the near future.

Integrated Services

As described, when the multiplex centre opened, it was envisioned as a multi-service delivery site which would include Elders, youth, and children and be a site of wellness and primary health services.

Programs and services, in addition to a culturally rich, developmental ECCD curriculum, that are delivered *inside* the child care centre itself have gradually evolved to include:

- Occupational therapy, provided by a professional seconded from a regional child care service.
- Supported child care, provided by certified child care practitioners assigned to individual children with diagnosed special needs.
- Developmental monitoring, assessment, and referral, provided by a special needs professional assigned from a regional child care service.
- Speech-Language Pathology services including training and consultation to staff and monitoring, diagnostic, and early intervention services to children.

- Preventive dentistry, provided by a dentist and the community health nurse, who consult with ECCD staff on dental care, monitor children's dental health, and provide referrals.

Co-Located Services

Programs and services that are delivered in the multiplex so that they are co-located with the ECCD program, now include:

- Mother Goose – a pre-literacy skills enhancement program for children and their primary caregivers;

- Best Babies – a support and education group for parents of infants;

- Other parenting education and support groups;

- Parent information bulletin board, resource table, and computer with internet access for information search and retrieval;

- Community health representative;

- Support groups facilitated by community employees such as the Community Health Representative or staff from contracted agencies such as the regional family support services non-profit agency;

- Public health nurse

- Hanen Early Language Facilitation Programs

- National Native Drug and Alcohol Abuse Program (NADAAP)

counsellor

- Meeting space for several Twelve Step programs (e.g., Alcoholics Anonymous, Narcotics Anonymous)

- Tobacco reduction support worker;

- Diabetes prevention worker;
- Optometry service

The multiplex includes a large multi-purpose gathering room. Although this room was intended initially for Elders, it quickly became a community centre for special community programs and events. There are also several other meeting rooms around the central gathering space, which are typically booked throughout the week for groups meetings addressing a range of aspects of child and family life.

Articulation with other community services.

Two other family serving structures are located near the ECCD facility. These include: a Wellness Centre that houses a child protection worker, two family support workers, and the tribal police; and a large, full service band-operated school.

The foundational role of ECCD in community ecologies.

The evolution of community services, beginning with a partnership to deliver community-based training in Child and Youth Care, and subsequent initiation of ECCD programs, was part of a considered plan for community self-sufficiency. A community administrator explained that the journey to achieving this vision began with a declaration of independence made by the hereditary chiefs of the Stl'atl'imx people in 1911. The community cherishes goals of cultural revitalization, increased health and wellness, improved education outcomes at all levels, and economic development. The community is unified in its understanding of optimal developmental conditions for children as the foundation for achieving these goals. The child care program was planned as part of a foundation element for a comprehensive, integrated community health centre that would

proactively promote optimal health and development throughout the lifespan, within a community setting infused with the community’s culture and Indigenous language.

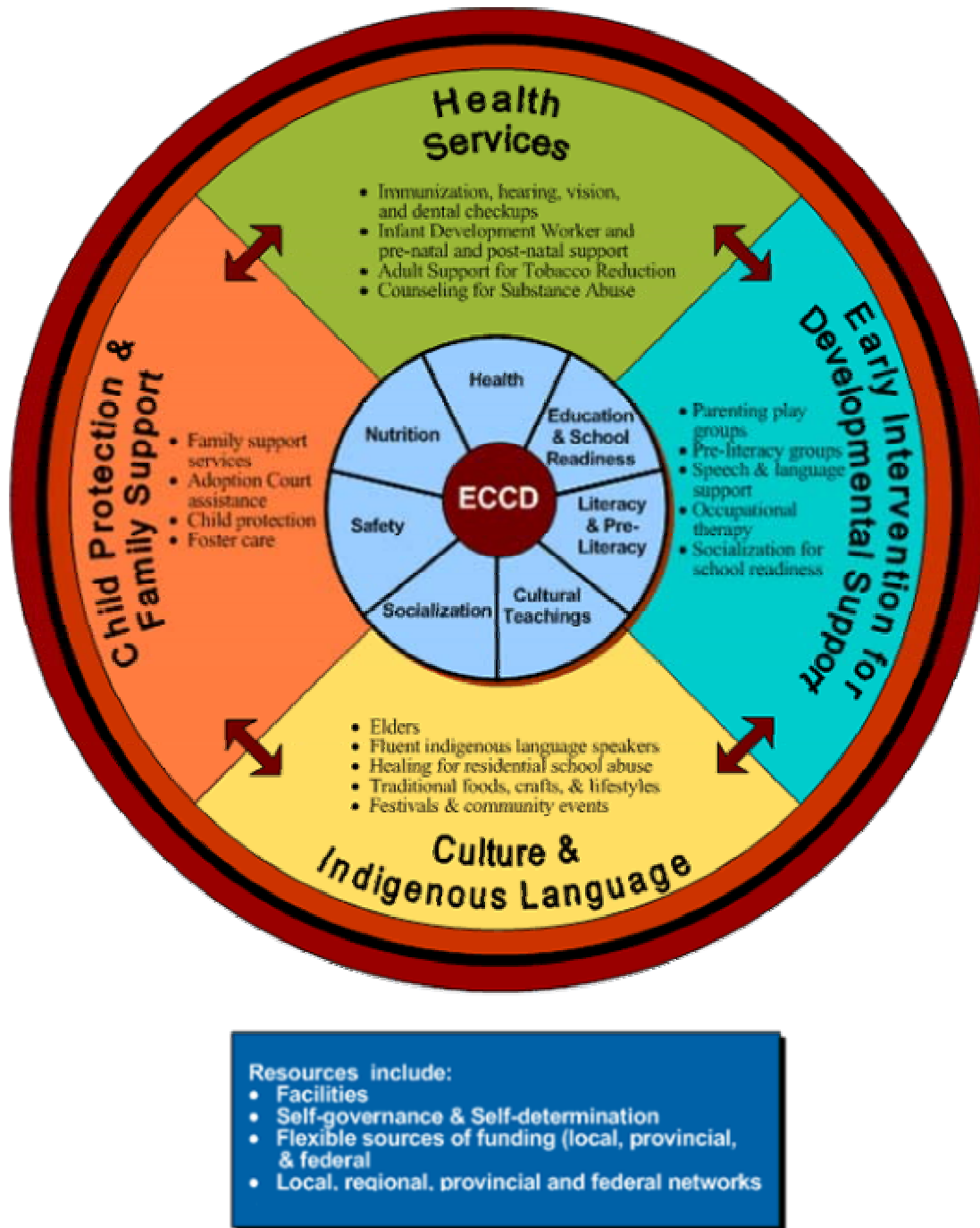


Figure 1: ECCD as ‘Hook’ and ‘Hub’ in Development of Community-Based Services

Figure 1 shows the location of the centre-based ECCD program within an inter-sectoral service system in the First Nation that is the focus of the current research report.

Discussion

ECCD as a hook and hub for community renewal and consolidation

The cases documented in this report illustrate how, when a community begins a development process with the well-being of the community's children as the starting point, the focus on young children can work as a 'hook' to attract and secure community commitment and action, and the ECCD program can become a hub of community-serving programs and activities. The well-being of children is a top priority for many adults in First Nations, as it is in non-Indigenous communities. Many adults may be willing to seek services for their infant or young child, although they may be reluctant to begin a connection with a community health agency by seeking services for themselves. When parents or grandparents bring a child for child care, or drop by a child care centre for a parenting class, they are exposed to community service providers and the kinds of service available through the centre. When the centre is located in their own community and it is culturally safe, the services available are both geographically and culturally accessible. This increases subscription by community members to programs such as parent support groups, counselling, health education, and preventive health services as well as to cultural and community events. This in turn promotes social inclusion of children and families who may otherwise be isolated, it builds community cohesion, and facilitates cultural and Indigenous language transmission. As one young man in

Community 3 remarked: *“Ever since this place happened, I feel like people can come out more and get the help and support they need. This child care program has been like a magnet that has drawn us together and keeps us here, doing things to help and heal ourselves and that will hopefully make our community stronger and a better place for our children and everyone who lives here and even some people who want to move back here.”*

The community initiatives described in this report illustrate the three postulates outlined initially: (1) that services appropriate to Indigenous people should conceive of child and family wellness holistically, as ecologically contextualized and embedded within community development and health; (2) that training and services to support the holistic, community-embedded goals of many Indigenous communities must be based on a recognition of community members prior experiences with health, social, and education services since colonial domination, and a recognition of the increased likelihood of success of population health approaches that involve and support the whole family, are community-based, community-operated, and culturally safe; and (3) that the Indigenous community whose improved health is the goal should be involved in planning, operating and evaluating population health initiatives from the outset.

The circumstances, resources, and goals of a community combine to create certain possibilities and ways of working to promote health and well-being in a community of children and families. Each region or community faces a unique set of barriers, goals, and assets. The need for bureaucracies to recognize and support flexible program strategies and use of funding is a strong recommendation of the Romanow Commission in reference both to rural and remote health and to Aboriginal health (Romanow, 2002).

The three groups of First Nations featured in this report have evolved systems of program delivery that have some commonalities and some unique features. They have each used different funding sources, administrative structures, purposes, and ways of working. These distinctive features result in different kinds of benefits and achievements. But all three communities have demonstrated how using ‘ECCD as hook and hub’ can assure developmental supports for children, enable primary health service delivery, and provide a portal for families to access and receive specialized services in a coordinated way. The stories of the communities described here hold promise not only for other Indigenous communities but for all of Canada and beyond. These stories can inspire other communities to persist toward the goal of accessible, affordable, integrated, logically cohesive and socio-culturally congruent systems of services to promote child and family wellness.

References

Aboriginal Committee, Community Panel (1992). *Liberating our children, liberating our Nation*. Victoria, BC: Family and Children’s Services Legislation Review.

Aboriginal Health Association of BC. (Nov. 1999). *Health Authorities Handbook on Aboriginal Health*. West Vancouver, BC: author.

Assembly of First Nations (1989). *Recommendation 39. Report of the national inquiry into First Nations child care*. Summerstown, ON: Assembly of First Nations National Indian Brotherhood.

- Ball, J. (2002). A Generative Curriculum Model for Early Childhood Care and Development in Indigenous communities in Canada (pp. 198- 216). In K. Boven (Nuffic) & J. Morohashi (UNESCO/MOST) (Eds.). Best practices using Indigenous knowledge. The Hague: Nuffic-OS/IK Unit. www.nuffic.nl/ik-pages.
- Ball, J., & Pence, A., (1999). Beyond developmentally appropriate practice: Developing community and culturally appropriate practice. *Young Children*, March, 46-50.
- Ball, J. (2001). Constructing knowledge and training curricula about early childhood care and development in Canadian Aboriginal communities. Caledon Institute of Social Policy. Ottawa: Renouf Publishing. ISBN: 1-55382-000-2.
- Ball, J., Leo, C., & Pierre, M. (2000). Profile: Mount Currie First Nation: Aboriginal child and youth care program. *Interaction/Ideas* (Journal of the Canadian Child Care Federation). REF
- Battiste, M. (Ed.). (2000). Reclaiming Indigenous voice and vision. Vancouver: UBC Press.
- Canadian Child Care Federation (1994). Assuring Quality in Child Care: Part II: A national strategy for assuring quality in child care. *Brief submitted to the Standing*

Committee on Human Resources Development. As printed from <http://www.cfc-efc.ca/docs/cccf/00000335.htm>. May 15, 2003.

Child Care Resource and Research Unit (1997). *Child Care in Canada: Provinces and Territories 1995*. Victoria, BC: Author. As printed May 15, 2003 from http://www.childcarecanada.org/resources/prov_terr/prvtrr63.html.

de Leeuw, S., Fiske, J., & Greenwood, M. (2002). *Rural, remote and North of 51: Service provision and substance abuse related special needs in the British Columbia's hinterlands*. Prince George, BC: Substance abuse task force of the Centre of Excellence for Children and Adolescents with Special Needs.

First Nations and Inuit Health Branch, Health Canada. (1999) *Second Diagnostic on the Health of First Nations and Inuit People in Canada*. As printed from

First Nations and Inuit Health Branch, Health Canada (2003). *A Statistical Profile on the Health of First Nations in Canada*. Ottawa, ON: author. printed from

First Nations and Inuit Health Branch, Health Canada. *Aboriginal Head Start*. As printed from <http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/cp/fnhisor/introduction.htm> May 15, 2003.

Greenwood, M. (2003, March). BC First Nations children: Our families, our communities, our future. Paper prepared for at the Putting Children First conference, sponsored by the BC First Nations Early Childhood Development Roundtable, British Columbia as printed May 15, 2003 from http://www.designingnations.com/Putting_Children_Agenda.htm.

Greenwood, M. (1998). Aboriginal child care in review. Part 2. Caring for Our Children Newsletter (Aboriginal Child Care Society of B.C.), 3 (1), 6-11.

Greenwood, M., & Shawana, P. (2000). Whispered gently through time. First Nations Quality Child Care: A National Study. Ottawa: Assembly of First Nations.

Government of Canada (2002a). Federal/Provincial/Territorial Early Childhood Development Agreement. The well-being of Canada's young children. Available at www.socialunion.gc.ca

Government of Canada (2002b). Federal/Provincial/Territorial Early Childhood Development Agreement. Early childhood development activities and expenditures. Available at www.socialunion.gc.ca

Haddad, L. (2001) An integrated approach to early childhood education and care. A paper prepared under the sponsorship of UNESCO/ Swedish Ministry of Education and

Science Conference on Early Childhood Education and Care (Stockholm, June 13-15, 2001).

Joint Evaluation Working Group (JEWG) for the Canada/British Columbia Strategic Initiative: Improved Access to Child Care (Oct. 1997). Overview Report: Formative evaluation of the British Columbia improved access to child care project. Victoria, BC: Ministry for Children and Families, Province of British Columbia.

Kantor, R., Elgas, P.M., & Fernie, D.E. (1998). Cultural knowledge and social competence within a preschool peer-culture group (pp. 133-154). In M. Woodhead, D. Faulkner, & K. Littleton (Eds.). *Cultural worlds of early childhood*. London: The Open University.

Long, D.A., & Dickason, O.P. (1996). *Visions of the heart: Canadian Aboriginal issues*. Toronto: Harcourt Brace.

Northern and Rural Health Task Force (1995). *Report of the Northern and Rural Health Task Force*. Victoria, BC: Province of British Columbia.

O'Donoghue, L. (1998). Towards a culture of improving Indigenous health in Australia. *Australian Journal of Rural Health* (7), Dec., pp. 64-69.

O’Gara, C., Lusk, D., Canahuati, J., Yablick, G., & Huffman, S., (1999). Qualities of caring: Good practices in infant and toddlers care group. Washington, D.C.: Early Child Development Education, the World Bank.

Pence, A., & Ball, J. (1999). Two sides of an eagle’s feather: Co-constructing ECCD training curricula in university partnerships with Canadian First Nations communities. In H. Penn (Ed.), *Theory, policy and practice in early childhood services* (pp. 36-47). Buckingham, UK: Open University Press.

Province of British Columbia, Vital Statistics (2002). *Regional Analysis of Status Indians in British Columbia, 1991 – 2001; Birth Related and Mortality Summaries for British Columbia and 16 Health Service Delivery Areas.*

Rogoff, B., Mosier, C., Mistry, J., & Goncu, A. (1998). Toddlers’ guided participation with their caregivers in cultural activity (pp. 225-249). In M. Woodhead, D. Faulkner, & K. Littleton (Eds.). *Cultural worlds of early childhood.* London: The Open University.

Romanow, R.J. (2002). *Building on values: The future of health care in Canada.* Final Report of the Commission on the Future of Health Care in Canada. Ottawa: National Library of Canada.

Shonkoff, J.P., & Phillips, D.A., (Eds.) (2000). From neurons to neighborhoods: The science of early childhood development. Washington, DC: National Academy Press.

Stephenson, P.H., Elliott, S.J., Foster, L.T. & Harris, J. (1995). A persistent spirit: Towards understanding Aboriginal health in British Columbia. Victoria, BC: Canadian Western Geographical Series, Vol. 31. University of Victoria.

Super, C.M., & Harkness, S. (1998). The development of affect in infancy and early childhood (pp. 34-47). In M. Woodhead, D. Faulkner, & K. Littleton (Eds.). Cultural worlds of early childhood. London: The Open University.

Swadner, B. & Kabiru, M. (2000) Does the village still raise the child? A collaborative study of changing child-rearing and early education in Kenya. Albany, NY: State University of New York Press.

UNICEF (Bellamy, C.) (2001). The state of the world's children report for 2001. New York, NY: United Nations Children's Fund, UNICEF.

Woodhead, M. (1996). In search of the rainbow: Pathways to quality in large scale programmes for young disadvantaged children. The Hague: Bernard van Leer Foundation.