Early childhood Development and First Nations Children

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The Assembly of First Nations

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Children Learn What They Live

If children live with criticism,
They learn to condemn
If children live with hostility
The learn to fight
If children live with fear
They learn to be apprehensive
If children live with ridicule
They learn to be shy
If children life with shame
They learn to feel guilty
If children live with tolerance
They learn to be patient
If children live with encouragement
They learn confidence
If children live with praise
They learn to appreciate
If children live with approval
They learn to like themselves
If children live with acceptance
They learn to find love in the world.

Source: The Bureau for At-Risk Children

Executive Summary
Early Childhood Development and First Nations Children
Assembly of First Nations

Early years researchers from many disciplines are now beginning to understand the crucial nature of child development as it pertains to the early years and its effects on learning behavior and health in the later stages of life. We now know that experiences and environments during early child development, including the active engagement of parents, ***are critical to brain development for children in their early years.*** New evidence indicates, what parents have always known, ***that babies and young children need love and care***.

The new thinking of scientists related to the early development of a child's brain hinges on the new belief that there is a complex interplay between the genes ***we are born with*** and ***the experiences we have***. Early experiences have a decisive impact on the development of the brain and the nature and long term extent of adult capacities. Early childhood interactions ***don't just create the context***, they directly ***affect the way the brain is "wired."*** By the time children reach age three, their brain's are twice as active as those of adults and during adolescence their brain activity level actually decreases.

First Nations children in Canada are ***at risk***. They are at risk from conception right through their early to their later years of life. This is the result of crushing poverty conditions that we know plagues nearly every First Nation community to one degree or another. Without our children we will have no one to carry on our traditions, our languages and our legacies. Without our children we will have no future.

The health of a community and a Nation is evidenced by the social conditions and environment of its inhabitants. The following matrix indicates the risk factors that can be equated with assessing community health, need and resiliency particularly as it relates to the future of our children.

Characteristics of Risk to First Nations Children

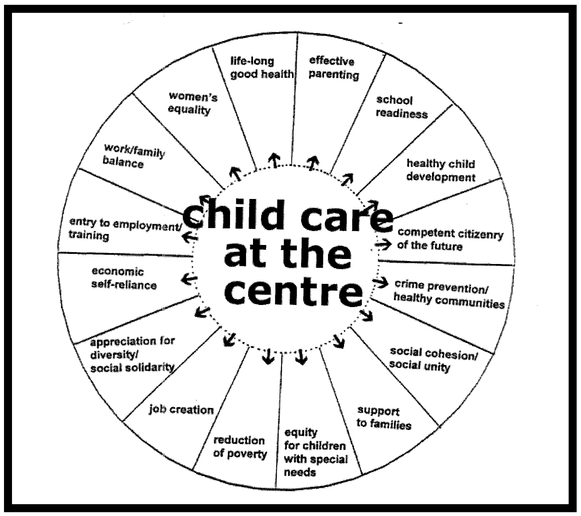
Risk Factor Category	Characteristics of Risk
Community Environment	Poverty, high unemployment, inadequate housing, cultural devaluation, culture and language barriers, low educational levels, low achievement expectations from society
Family Environment	Financial strain; large, overcrowded family; unemployed or underemployed parents; parents with little education; single female parent without family/other support; family violence or conflict; frequent family moves; low parent/child contact
Vulnerability of the child	Child of an alcohol, tobacco or drug abuser; birth defects and physical disabilities; birth defects and physical disabilities; physical or mental health problems
Early behavior problems	Learning disabilities, emotional problems, inability to cope with stress, low self-esteem, aggressiveness
Adolescent Problems	School failure and drop out; at risk of dropping out; violent acts; drug use and abuse; teenage pregnancy/teen parenthood; unemployed/under-employed; suicidal

It is clear Canada has a long way to go in conforming to the needs of children who have a right to a ***"standard of living that is adequate for the child's physical, mental, spiritual and social development ."***

One of the most significant problems identified to First Nations control over child care and early childhood development programming is the lack of jurisdiction. The history of jurisdictional wrangling between First Nations and the federal government is tied back to ***Section 91(24) of the Act and*** the ***Indian Act.*** Most provinces disclaim responsibility for First Nations which they assert remains with the federal government. The federal government in turn disclaims responsibility - with neither being willing to give the responsibility to First Nations themselves. The result has been over time that child care and child welfare services have been seriously mismanaged. This has changed somewhat, however, through the implementation in the mid-1990's of programs such as First Nations Aboriginal Head Start On-Reserve (HC), First Nations/Inuit Child Care Initiative (HRDC), National Child Benefit and First Nations Child and Family Services (DIAND).

Quality child care is critical to the development of children. Poor quality is shown to have negative effects on children – regardless of social class. High quality childcare is sensitive, responsive, personal, developmentally appropriate, culturally appropriate and not custodial. High quality child care is also characterized by small group sizes, well trained staff, adequate health, safety and physical environment precautions, high adult to child ratios and stable consistent care giving.

Through our research the following childcare framework (***Childcare Resource and Research Centre)*** was used to guide the discussion in this paper. This paper was designed to facilitate discussions among First Nations leaders, technicians and government officials towards a national framework for First Nations early childhood development.



In summary this paper proposes that the symptoms of poverty are devastating to First Nation communities especially when reforms to reverse poverty's trends have been unsuccessful. Empowerment in any society requires its' people to be pro-active. First Nations communities are no different. To achieve long term sustainable communities policy makers would be wise to encourage and support education, training and entrepreneurial endeavors. Hand and hand with these initiatives are the support systems necessary to ensure success. This particularly relates to child care and early childhood development.

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Introduction

Children are the most precious resource of our Nations. They are the link to the past generations, the enjoyment of present generations, and the hope for the future. First Nations intend to prepare their children to carry on their cultures, traditions and governments. Because early childhood development is the beginning of the shaping of the minds and values of our young children, it is vitally important that First Nation governments have jurisdiction over the programs which will have such a lasting and significant impact. The care and nurturing of our children contributes to the development and potential of our future generations. Safe nurturing environments are required to ensure that they will grow, play and learn in order to be prepared for school and for life.

Background

First Nation children are the fastest growing segment of the Aboriginal population in Canada. In 1996, 35% (281,000) of Aboriginal people were younger than 15 years of age compared to about 21% for Canada. Life expectancy at birth is seven to eight years less for registered First Nations persons than for Canadians generally. Death rates for First Nation infants from injuries are four times the rate of non-First Nation infants (CICH, 2000). Children with disabilities or identified special needs are unlikely to survive or receive the services they need. FAS rates are 30 times the general population and the cost of meeting the needs of someone who is severely affected by FAS over a lifetime is $1 to $1.5 million (RCAP, 1996).

The First Nation status population according to Statistics Canada is estimated to increase to nearly 1 million by 2005. Given the current birth rate trends the relative youthfulness of the First Nation population is expected to continue to be representative of this phenomenon for several generations to come. Children are our future. They are the joy for us today and the hope for us tomorrow.

Statement of the Problem

Early years research from many disciplines, including sociology, neuroscience, pediatrics, epidemiology and developmental psychology now are beginning to understand the crucial nature of child development as it pertains to the early years and its effects on learning behavior and health in the later stages of life. We now know that experiences and environments during early child development, including the active engagement of parents, ***are critical to brain development for children in their early years*** (Mustard, 1999). New evidence indicates, what parents have always known, ***that babies and young children need love and care***. With the new understanding of brain development, research has proven that good nurturing, good nutrition and good health in early life creates the foundation for brain development which will inevitably determine the foundation of the brain for the later stages of life (1999 pg. 25).

What the Research Says about Early Brain Development

Scientists have now discovered that a tremendous amount of the brain development of a child occurs between conception and age one. There is also a new understanding of how the stimuli from a child's experiences before the age of three influences the "wiring" of the nerve cells and neural pathways of the brain. Human development, therefore, is not a matter of "nature versus nurture, but rather the interplay of nature and nurturing together." Considerable brain development also takes place before birth. At the beginning of the embryonic period (two weeks after conception), the neural tube, which will form the brain and spinal cord, is formed. Most of a human's lifetime supply of brain cells is produced between the fourth and seventh months of gestation. A full-term baby comes into the world with billions of neurons which have to form quadrillions of connections to function effectively. In response to stimuli from the environment through the eyes, ears, nose, tongue, skin, muscle joints, etc. the neurons allow the brain to recognize the signals of the neural pathways connected to the sensory organs. The most intensive part of this process is ***during the first three years of life***, particularly in ***utero*** and ***during the first year***. It then continues with decreasing activity until age 10 (1999, p. 27).

The new thinking of scientists related to the early development of a child's brain hinges on the new belief that there is a complex interplay between the genes ***we are born with*** and ***the experiences we have***. Early experiences have a decisive impact on the development of the brain and the nature and long term extent of adult capacities. Early childhood interactions ***don't just create the context***, they directly ***affect the way the brain is "wired."*** By the time children reach age three, their brain's are twice as active as those of adults and during adolescence their brain activity level actually decreases (1999, p. 28).

To prove their point scientists did studies on the effect of drugs like alcohol, cocaine and tobacco on the human fetus to determine the resulting long term effect on neurological, as well as, physical development. Studies found that the neurological functioning of full-term newborns who were exposed to cocaine during the prenatal period was compromised. Compared to newborns who were unexposed, cocaine-exposed newborns had smaller head circumferences, higher rates of interuterine growth delay and neurological abnormalities (1999, p.34). Another study similarly found that two year old children who were exposed to cocaine and alcohol during the prenatal period had poorer motor development than a control group (ibid).

Poor quality child care settings can also create negative effects on a child's early development. The preliminary results from a large American study of early child care suggests that, for ***vulnerable children*** or ***children at risk***, a low-quality child care program seems to ***aggravate*** their problems (1999, p. 37). Research indicates that full-time attendance in poor quality preschool child care programs has a ***negative*** impact on children's social and language development. ***In fact, it appears that having a supportive family with adequate resources*** <u>may not compensate</u> ***for poor child care experiences*** <u>***outside the home***</u> (ibid).

The major concern of researchers now is what happens to children who have a less than optimum early childhood. They know ***some will not learn well in school; some will have behavior problems; some will have health problems; and some resilient ones will do well***. The purpose of this paper is to discuss the options of First Nation communities where we know First Nation children are exposed to poor living conditions and various risk factors that will ultimately affect their long term ability for healthy development.

What the Research Says about Healthy Pregnancies and Births

A healthy pregnancy increases the likelihood of full-term uncomplicated births, normal birthweights and healthy brain development. Research indicates that healthy mothers are more likely to have healthy pregnancies and deliver healthy babies. Research also indicates that significant brain development occurs when infants are still in the uterus (1999, p. 42). The avoidance of smoking, alcohol consumption and other drug use during pregnancy reduces the risk of pre-term births and low birthweights. There is also strong evidence that a mother's nutrition has a significant influence on her child's later health. The act of breastfeeding provides frequent opportunities for skin-to-skin touch and smell stimulation. The ***American Academy of Pediatrics***, for example, recommends that mothers breastfeed their infants for a minimum of one year (ibid). Where breastfeeding is not an option, the mother can follow breastfeeding practices by holding and cuddling the baby while feeding. Another study that looked at differences between formula-fed and breastfed children at 18 months found that breastfed babies did better on mental development tests, even with adjustments for social and demographic influences.

When a control group of low-risk children who received good nurturing and nourishment was compared to children who received neither stimulation nor good nourishment, researchers found that 50% development was achieved for the children who received either stimulation or good nutrition over a two year period. In contrast, children who received neither stimulation nor good nutrition developed poorly and may have been permanently disabled. The children who received both good nutrition and stimulation reached the same stage of development as the control group (1999, 9. 43).

Finally, in a British report in the ***Inequalities of Health***, British researchers reported "while remediable risk factors affecting health occur throughout the life course, childhood is a critical and vulnerable stage where poor socioeconomic circumstances have lasting effects." Where samples of births were used to determine the influence of early life on subsequent mental and physical health, and development over time, adverse outcomes such as mental illness, delinquency and unemployment were reported. The end result was the suggestion by researchers that policies which reduce early adverse influences may result in multiple benefits, not only throughout the life course of that child but to the next generation as well (1999, p. 44).

In summary, well designed child development programs that involve parents benefit the children and in many cases the families as well. Early child development can be provided in a variety of settings. These include day care or child are centres, home-based child care centres, preschool programs such as junior and senior kindergarten, headstart programs, etc. ***It is not the setting that defines early child development*** (1999, pg. 45) ***it is the activities.*** Activities must focus on parent interaction with their children and play based problem solving with other children that stimulate early brain development through the sensing pathways.

Healthy Children are Necessary for Healthy First Nations

Among early Aboriginal societies the birth and growth of children was a matter for ceremony and thanksgiving. Children were at the centre of communal life. Children were showered with attention and taken everywhere with their parents. Even today, children are often seen at social gatherings, meetings or other events in First Nation communities. The aim of

Native traditional upbringing was to bring children up in self-discipline and self-reliance. Children were respected as contributing members of society at an early age (AFN, 1989, p. 7). Education and life in traditional culture were one and the same. Children learned by observing and emulating; only as they grew older were they told what to do. Legends and stories told the child of his or her duties: reverence for the aged, dignity and self-control. Traditional child-rearing was of the highest human quality and of a holistic nature, treating life as a continuum and giving equal emphasis to the health of the community, family and child (1989, p. 19). The imposition of European values , the denigration of culture, and the nature and failure of social welfare and education policies, combined to inflict severe damage on First Nations culture as a whole. This damage is responsible for many of the conditions existing in First Nation communities today.

Given what we know about early childhood development it is very clear that First Nations children in Canada are ***at risk***. They are at risk from conception right through their early years to their later years of life. This is the result of crushing poverty conditions that we know plagues nearly every First Nation community to one degree or another. Without our children we will have no future. Without our children we will have no one to carry on our traditions, our languages and our legacies. As long as we continue to do nothing our children will continue to be afflicted with disabilities which can be prevented. They will also continue to die because the injuries and diseases that they are exposed to could have been prevented and were not. It is the responsibility of Canada to ensure that the First Nations children of this country have an equal opportunity to life, health and happiness. According to the ***United Nations Convention on the Rights of the Child*** every child has the right to live in "***an atmosphere of happiness, love and understanding***." Those responsible for children in an official capacity must ensure that "***the best interests of the child shall be a primary consideration***" (Article 3). The Convention specifies three broad areas of rights in order to promote children's interests: ***provision rights to goods, services and resources; protection rights from neglect, abuse, exploitation and discrimination***; and ***participation rights giving children proper information in order to enable them to make decisions about and contribute to the circumstances of*** their everyday life.

The health of a community and a Nation is evidenced by the social conditions and environment of its inhabitants. The data in the following tables describes the conditions existing in First Nation communities across the country. These data are collected from a variety of sources such as Statistics Canada, the Aboriginal Peoples Survey, the DIAND ***Indian*** Register and the First Nations and Inuit Regional Health Survey. They are presented in table format to indicate a matrix of risk and protective factors that can be equated with assessing community health, need and resiliency. These data are followed by another table of findings related to early childhood development, health, nutrition, stages of pregnancy and long term child development. These data were gleaned from research conducted by the Aboriginal Nurses Association of Canada.

Table 1 (a)
Risk Factors for First Nation and Aboriginal Children in Canada

Risk Factor Category	Characteristic	Statistical Indicators of Risk
Community Environment	Poverty	*Most Aboriginal people are at or below the poverty line. In major western cities, four times as many Aboriginal people as other citizens are below the poverty line.*
	High unemployment	*50% of First Nation children living on or off-reserve are living in poverty. Aboriginal people are less active in the labour force. They represent 47% of the those employed on-reserve and 57% off-reserve compared to the national labor force employment rate of 68%*
	Inadequate Housing	*First Nations houses on-reserve are ten times more likely to be crowded than houses the general population live in. Only 54% of houses have adequate water supplies and 47% have adequate sewage disposal. More than 20% of First Nations have problems with their water supply which threatens health and safety.*
	Cultural devaluation	*There are 633 First Nations in Canada, 52 Nations and cultural groups. There are 57 Aboriginal languages and 12 language families represented in Canada and only 3 languages are predicted to survive – Cree, Inuktitut and Ojibway.*
	Culture and language barriers	*According to Census and APS data 21.9% of Aboriginal persons age 5-14, 27.5% aged 15-24, 36.7% aged 25-54 and 63.1% aged 55+ speak an Aboriginal language. As the Elders die the languages are dying with them.*
	Low educational levels	*The education of Aboriginal people lags behind other Canadians. 18% of Aboriginal people 15 years or older have less than grade 9 compared to 13.8% for Canadians, 8.1% Aboriginal people are high school graduates compared to 12.9% for Canadians. 4.7% Aboriginal people have University degrees compared to 11.6% Canadians.*
	Low achievement expectations from society	*69% of First Nation youth never complete high school compared to 31% of the general youth population for Canada. Rates of First Nation youth aged 20-24 attending university was 12% compared to 35% for the general population. Completion rates for First Nation youth are approximately 31% compared to 58% for the general population.*
Family Environment	Alcohol, tobacco and other dependency of parents	*According to the FNIRHS 78% of respondents said they used tobacco in non-traditional ways. 62% smoked cigarettes, 4% used snuff and 1% used chewing tobacco. The majority of the population of smokers are under the age of 40 and the smoking rates are up to 72% for the youngest adult age group (age 20-24). Smoking for Aboriginal children begins as early as 6 to 8 years (0-8%) but rapidly increases at age 11 to 12 (10% to 65%) with a peak initiation at about age 16 years.*
	Parental abuse and neglect	*25% of Aboriginal adults reported sexual abuse is a problem in their community and 15% reported rape as problems. 25 % of First Nation youth reside in one parent households and 18% live in non-family settings. Compared to their non-Aboriginal counterparts First Nations youth are 1.6 more times likely to report living in a non-family setting. Mortality rates among Aboriginal youth indicate there are 250 deaths per 100,000 persons, a rate of approximately 3.6 times higher than deaths reported for all Canadian youth.*

Table 1(b)
Risk Factors for First Nation and Aboriginal Children in Canada

Risk Factor Category	Characteristic	Statistical Indicators of Risk
	Financial strain	*More than 45% of all First Nation youth were living in a low income household, a rate of roughly 1.9 times that of non-First Nation youth*
	Large, overcrowded family	*More than half (52%) of First Nation households live in homes that fall below one or more of the housing standards as compared to 32% for Non-First Nation households*
	Unemployed or underemployed parents	*Earned income per employed Aboriginal person in 1991 was $14,561 compared to $24,001 for the general Canadian population. First Nations people are economically disadvantaged in that they earn an average of half what Canadians earn and subsist on social assistance at a rate of five times higher than the rest of the Canadian population.*
	Parents with little education	*Half of the First Nations school age population do not complete high school.*
	Single female parent without family/other support	*32% of Aboriginal children live in households with a lone-parent and are at elevated risk for living in poverty*
	Family violence or conflict	*39% of Aboriginal adults reported that family violence is a problem in their community. Incarceration rates of Aboriginal people are 5-6 times higher than the national average. The highest rates of Aboriginal sentenced admissions were in the NWT (80%), the prairies (50%) and BC (20%)*
	Frequent family moves	*High rates of mobility characterize the First Nation youth population. Between 1995 and 1996, more than one third of First Nation youth reported a change in residence, a rate roughly 1.4 times higher than that of non-Aboriginal youth*
	Low parent/child contact	*5% of First Nations children were in the custody of Child and Family services in 1996/97.*
Vulnerability of the Child	Child of an alcohol, tobacco or drug abuser	*Incidences of FAS/FAE in First Nation communities are 30 times the national average.*
	Birth defects and physical disabilities	*Aboriginal people are more likely than other Canadians to have hearing, sight and speech difficulties. Mobility impairment occurs at the same rate for both populations. The rate of disability for Aboriginal people is 31%.*
	Physical or mental health problems	*The most prevalent health problems among First Nation children include ear infections, respiratory conditions, broken bones, emotional and behavioral problems. First Nation children are also at a greater risk of contracting diseases such as tuberculosis, Hepatitis A and B, meningitis and gastroentieritis than non-First Nation children.*

Table 1(c)
Risk Factors for First Nation and Aboriginal Children in Canada

Risk Factor Category	Characteristic	Statistical Indicators of Risk
	Learning disabilities	*Aboriginal youth are at elevated risk of suffering from a physical developmental or learning disability. According to the APS nearly a third of all First Nations people aged 15 and older had a disability which is more than double the national rate during the same period*
Early Behavior Problems	Emotional problems	*The suicide rates for First Nations females are 4 times higher than for Canadian females and 32.6 times higher for First Nation males than Canadian males*
	Inability to cope with stress	*Solvent abuse by youth is a particular concern: 22% of First Nations youth who report solvent abuse are chronic users and come from homes where there is financial hardship, neglect, family conflict or child abuse. Suicide rates for registered First Nation youth ages 15-24 are eight times higher than the national rate for females and five times higher for males.*
	Low self-esteem	*Incidences of FAS/FAE in First Nation communities are 30 times the national average*
	Aggressiveness	*Rates of incarceration (age group 15-19) are nine times higher among the First Nation population at approximately 45.7 per 10,000 compared to non-First Nation youth at 4.9 per 10,0000.*
Adolescent Problems	School failure and dropout	*65% of First Nation youth never complete high school compared to 31% of non-Aboriginal children.*
	At risk of dropping out	*31% of First Nation youth do not attend school compared to the 69% who do*
	Violent Acts	*Rates of incarceration for violent crimes are nearly 9 times higher for First Nation youth at 103 per 10,000 compared rates of 11.8 per 10,000*
	Drug use and abuse	*62% of First Nations people aged 15 and over perceive alcohol abuse as a problem in their community while 48% state that drug abuse is an issue.*
	Teenage pregnancy/teen parenthood	*Aboriginal youth are at elevated risk of becoming pregnant at an early age and greater risk of contracting a sexually transmitted disease.*
	Unemployed/under-employed	*Earnings from employment per person aged 15+ First Nation persons = $9,140 compared to $17,020 for the Canadian population*
	Suicidal	*Suicide rates for registered First Nation youth ages 15-24 are eight times higher than the national rate for females and five times higher for males.*

Table 1(d)
Risk Factors for First Nation and Aboriginal Children in Canada

Risk Factor Category	Characteristic	Statistical Indicators of Risk
Negative Adolescent Behavior and Experience	**Lack of bonding to family, school, community**	***65% oF First Nation youth never complete high school compared to 31% of non-Aboriginal children. Rates of incarceration for violent crimes are nearly 9 times higher for First Nation youth at 103 per 10,000 compared rates of 11.8 per 10,000***
	Hopelessness	***Solvent abuse by youth is a particular concern: 22% of First Nations youth who report solvent abuse are chronic users and come from homes where there is financial hardship, neglect, family conflict or child abuse. Suicide rates or registered First Nation youth ages 15-24 are eight times higher than the national rate for females and five times higher for males.***
	Feelings of failure	***The most prevalent health problems among First Nation children include ear infections, respiratory conditions, broken bones, emotional and behavioral problems. Half of the First Nations school age population do not complete high school.***
	Vulnerability to negative peer pressure	***Solvent abuse by youth is a particular concern: 22% of First Nations youth who report solvent abuse are chronic users and come from homes where there is financial hardship, neglect, family conflict or child abuse***

Sources: Statistics Canada, Aboriginal Peoples Survey, DIAND Indian Register, Health Canada – Medical Services Branch, First Nations and Inuit Regional Health Survey, DIAND ***Gathering Strength***

Upon review of Table 1 (a-d) it is clear Canada has a long way to go in conforming to the ***UN Convention on the Rights of the Child***. As described earlier, Article 3 in particular points to the obligation of the state to ensure ***that all services for children shall conform with the standards established by competent authorities, particularly in areas of safety, health and in the number and suitability of their staff, as well as, competent supervision, and that due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background***." Article 20 further states that children have a right to a ***"standard of living that is adequate for the child's physical, mental, spiritual and social development ."***

The following table describes a matrix of risk factors for First Nations children from conception to early childhood. These are augmented with prevention strategies to address the issues raised by such stakeholders as families, communities, government and First Nations.

Table 2
Matrix of Risk Factors for Development of First Nation Children from Conception to Early Childhood and Findings Related to Prevention

Issue	Findings	Prevention Strategy
The Prenatal Period · The prenatal period begins at the time of conception. A normal pregnancy lasts about 40 weeks or nine months and is divided into three stages, each 3 months in length. This is a critical time for fetal organ development. Formed in the first trimester fetal organs continue to grow and develop throughout the second and third trimester until the child is ready to be born.	**Toxic Substances, nutrition, environmental contaminants** · **When the chemicals in cigarettes enter the unborn baby's blood, the oxygen supply to the baby can be reduced by 25%** · **There are no safe levels of alcohol that can be consumed during pregnancy.** · **Sudden Infant Death Syndrome (SIDS) occurs more frequently in infants whose mothers consumed cocaine or other illegal street drugs during pregnancy** · **Some prescription drugs have harmful effects on the fetus such as Accutane, antibiotics, tranquilizers, barbituates** · **Nearly 65% of disabilities can be reduced if measures such as health teaching and education and medical interventions are initiated at the first prenatal visit occurring around 12 weeks gestation and ending after the first week of life.** · **The baby is nurtured by the food received through the mothers' bloodstream. Nutrition counseling by a nutritionist or specially trained health provider ensures the essential nutrients to the fetus** · **Both the woman and unborn child can be seriously affected with a communicable/infectious disease** · **The health of the unborn child is influenced by the mother's emotional well-being. Low birth weight and irritability and crying frequently are a result of emotional stress during pregnancy.** · **Exposure to environmental contaminants could have a negative effect on the fetus and can result in respiratory disease; skin or eye problems poisoning, allergic reactions, neurological damage, genetic changes, birth defect and cancers.**	**Community Actions Required** · **Community awareness of the ill effects of tobacco smoke on the pregnant woman and her unborn child through presentations and written information or public announcements are required.** · **Screening, detection and counseling support for women who are high risk for alcohol consumption are required.** · **Increased knowledge and awareness of FAS/FAE is required.** · **Prevention activities that include information workshops and talking circles for men, women and youth are required.** · **Culturally appropriate resource materials such as films, brochures, booklets, posters, etc. are required – prenatal education and care is a right of all prospective parents in Canada** · **Prenatal classes and outreach visits will increase the knowledge of prospective parents about the importance of proper nutrition** · **Ensure that immunization programs are established in the community** · **Advocate for mental wellness programs in all First Nations communities** · **Provide training to the health care providers in Aboriginal communities about household and environmental contaminants and their effect on the pregnant woman and the unborn child.**

Issue	Findings	Prevention Strategy
The Perinatal Period The perinatal period begins at the birth of the child and ends when the child reaches 4 weeks of age.	**Toxic substances, drugs and mental health** · **Alcohol consumption can slow down the production of milk and can affect the development of the nursing infant** · **Smoking and exposure to second hand smoke increases the risk of infant death and illness** · **Some drugs can be passed to the baby through the mother's breast milk** · **It is important for the mother and her family to receive emotional support during labour and delivery and in the perinatal period**	**Community Action Required** · **Training to community workers about alcohol and its negative effects to the infant and to the parents and how to recognize FAS/FAE** · **Availability of smoke cessation programs.** · **Drug rehabilitation referrals and services for new parents and nursing mothers.** · **Initiate Postpartum Parent Support programs in the community**
Issue The Postneonatal Period The postneonatal period begins after the perinatal phase at one month and lasts until the infant reaches one year of age. Physical and psychological development during the first year of life is very rapid. The postneonatal period must be closely monitored as this is the starting point for assessing the future health status of the child beyond the first year of life.	**Findings** **Sudden Infant Death Syndrome (SIDS), Injuries, Nutrition, Infectious Diseases** · **SIDS is the sudden death of an infant usually under one year of age which remains unexplained even after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history.** · **Postneonatal mortality rates for Aboriginal infants are 4 times greater than the overall Canadian population.** · **Injuries to children can be prevented through proper awareness and understanding of the causes of childhood injuries** · **Children must grow and develop properly during the postneonatal stage to ensure a healthy person in the future – close monitoring of the child's growth and development throughout the first year of life will ensure early identification of high risk infants who are likely to experience poor growth and development** · **In healthy mothers, breast milk is the most balanced and nourishing food to give the infant and should be the main source of nourishment during the postneonatal period.** · **Infectious diseases seriously affect the health and well being of Aboriginal children**	**Prevention Strategy** **Community Action Required** · **Recommend a smoke free environment for the infant.** · **Demonstrate proper positioning of the baby as recommended by the Canadian Pediatric Society** · **Advocate the use of seat belts and safety attachments for children and approved baby care seats. Also, offer First Aid, Cardio Pulmonary Resuscitation (CPR) and baby sitting courses for community members.** · **Initiate First Nation parenting courses involving Elders with knowledge of traditional parenting** · **Identify resource people and set up community-based breastfeeding support groups which include Elders** · **Lobby for resources to ensure breastfeeding mothers have healthy foods** · **Encourage and provide vaccines for tuberculosis and hepatitis B and meningitis** · **Provide community information about proper housing, water and sanitation, as well as, proper storage, handling and preparation of perishable foods.**

Issue	Findings	Prevention Strategy
Early Childhood **The early childhood period begins at one year and ends when the child reaches six years of age. The time from one to three years is the toddler stage, followed by the preschool period which continues from three to six years of age.**	**Injuries, nutrition, child development and growth, infectious diseases** · **Injuries can be prevented through proper community awareness** · **The mortality rate resulting from injuries for Aboriginal children between the ages of 1-14 years is 6 times the Canadian rate.** · **Fire, motor vehicle crashes and drowning are the three main causes of fatal injury for Aboriginal children.** · **Cigarette smoking is linked to about 50% of all fatal fires.** · **Aboriginal children require healthy home and community environments to grow and develop as healthy individuals with their physical, mental, emotional and spiritual aspects in balance** · **Proper nourishment in early childhood is essential for healthy growth and development.** · **Many infectious, yet preventable diseases, seriously affect the health and wellbeing of Aboriginal children. Ear infections and hearing loss may be the most widespread and most commonly known afflictions that affect Aboriginal children.** · **Many Aboriginal children experience poor dental health because of improper eating habits and inadequate dental hygiene. 91% of Aboriginal children have teeth affected by decay. Baby-bottle tooth decay is severe and may be the cause of more than 50% of poor dental health in First Nations communities.**	**Community Action Required** · **Injury prevention programs need to be implemented in all Aboriginal communities** · **Train health care providers in injury prevention** · **Provide First Aid training to community members** · **Demonstrate how to "baby proof" a home** · **Initiate early identification programs for at risk infants who are likely to experience poor growth and development.** · **Offer support groups for parents of developmentally delayed children.** · **Provide iron and vitamin supplements.** · **Do screening for nutrient –deficient conditions** · **Ensure prompt referral to medical care for infectious diseases** · **Ensure proper water and sewage systems are in place** · **Ensure adequate housing for First Nation families** · **Provide information about proper food storage and processing** · **Implement immunization programs and provide vaccines for all vaccine preventable diseases** · **Controlled and monitored flouride treatments of water supply are required.** · **Provide dental health programs that are implemented by dentists, dental hygienists or dental therapists in every community. `**

Source: Healthy Children Healthy Nations A Framework Document to Support Wellbeing of First Nations Children, from the Aboriginal Nurses Association of Canada, March 1996

About 4% of Aboriginal children are in the care of a child welfare agency as compared to 0.8% of the rest of the Canadian population of children. Protocols and procedures to detect abuse and neglect of children are required. Surveillance and mandatory reporting of children victims of child neglect are also required.

Traditionally Aboriginal people treated their children with great respect and consideration. As soon as the child was able to communicate, the main practices used for discipline was affectionate lecturing. The use of physical or corporal punishment by adults was virtually unknown. Parenting courses incorporating the community's traditional parenting techniques need to be developed and given in every community. Elders should also be encouraged to teach traditional parenting skills.

Evidence shows that there are high levels of depression accompanied by failure to achieve among Aboriginal children. At the Sioux Lookout Hospital in Ontario, for example, over 800 serious suicide attempts were seen over a six-year period. Traditional teachings provided to First Nation adults and children support the healthy development of self –esteem and a positive sense of identity. Communities need to hire and train Aboriginal mental health workers in every community. Crisis response teams need to use multi-disciplinary approaches in every community.

In summary, ***the best investment any society can make in its future is to assure the health and wellbeing of its children***. "Psychologically and physically sound children develop into healthy and contributing members of families, communities and nations."

The Ongoing Struggle for Equality in First Nation Child Related Services

The Assembly of First Nations in 1989 was authorized through the ***Child Care Initiatives Fund*** (from ***National Health and Welfare***) to conduct a ***National Inquiry into First Nations Child Care***. The objective of the Inquiry was to undertake a preliminary***, yet in-depth search*** of national First Nation needs and policy preferences to meet First Nations child care requirements. The goal was to give First Nation and non-First Nation policy makers and funding sources a better grasp of policy issues. Finally, it was hoped the Inquiry would "invite innovative programs, identify impediments to such programs and solicit solutions to child care problems."

The Inquiry found that child care services were essentially divided into two categories: ***child care*** and ***child welfare***. Both of which were inefficient, restrictive and failed to meet the needs of First Nation communities. Insistence on provincial standards and the imposition of regulations, coupled with the failure to see the family as a unit, did far more than good, according to the Inquiry (p. 22). Since Canada had no universal child care system or standards the federal government passed the responsibility for First Nations child care to the provinces. Each province and territory had its own bureaus and regulations which varied widely. The Inquiry determined, however, that one thing the provinces did have in common was the reluctance to provide the same services for First Nations people as they did to non- First Nations people.

The Inquiry also determined, through their hearings, that First Nations conceptions of child care differed radically from those of non-First Nations in that they were more holistic, relied on the extended family as caregivers and concentrated on ***prevention*** instead of ***intervention.*** They further determined that First Nation run daycare centres were far too scarce, under funded and were in dire need of capital expenditure dollars to upgrade facilities.

One of the most significant problems identified to First Nations control over child care programming, however, was the lack of jurisdiction. The history of jurisdictional wrangling between First Nations and the federal government is one that the Inquiry determined tied back to the ***British North America Act, section 91(24***), which gave the federal government responsibility for "***Indians and lands reserved for Indians***." "This clearly gave government the authority to act on child care as they so desired." In 1951 the government amended the ***Indian Act*** to allow provincial laws "***general application***" to apply "***to Indians, in the absence of federal or Indian by-laws (section 88)."*** Most provinces then disclaimed responsibility for First Nations which they asserted remained with the federal government . The federal government in turn disclaimed responsibility <u>with neither being willing to give the responsibility to First Nations themselves </u>(p. 31). The result was child care and child welfare services were seriously mismanaged through:

- Inappropriate decision making by workers who lacked the knowledge of First Nations traditions and culture
- Inappropriate training in early childhood training programs which ignored First Nation traditions and culture
- Inappropriate licensing requirements for daycare facilities which prohibited First Nations from qualifying in many cases at all. Many of these requirements also were not culturally appropriate for a First Nation child care facility
- Lack of resources and shortages of funding
- No jurisdiction which ultimately left First Nations people, especially women, facing a bleak future
- Obstructive bureaucracies because of lack of flexibility, and

- Lack of flexibility and appropriate services for First Nation children living off-reserve.

The final recommendations of the Inquiry commissioners were comprehensive and far reaching. In summary they were as follows:

1. ***First Nations child care must be addressed culturally and holistically. Child care must encompass First Nation values and traditions. For this reason, it is essential that child care programs must be placed within the culture of First Nation communities.***

2. ***Special needs children such as those affected by Fetal Alcohol Syndrome (FAS) and learning disabilities need to be addressed. This should be reflected in the training of the caregivers, a change in staff/child ratios for special needs children and a recognition of the extra costs involved.***

3. ***There is a need for a comprehensive child-care system in First Nation communities. Child care services should address the needs of children age 0-12. Infant care, after school care, respite care, seasonal and part time needs must all be considered.***

4. ***Parents must be assured of the opportunity to become involved, along with First Nation governments, in decisions concerning the operation and delivery of child care services.***

5. ***First Nations require a child care system which reflects the unique needs of First Nation society and will provide a comprehensive range of quality, accountable, community based, non-profit service for families requiring care.***

6. ***The services provided in First Nation communities must be culturally sensitive, non-profit, comprehensive, accessible, of high quality, affordable and administered by appropriate First Nation caregivers whenever possible.***

7. ***To ensure quality, it is essential that certain standards be met by the caregiver. Standards relating to child ratios and health and safety standards need to be met. However, determining those standards and how to monitor services should be decided by the parents using the service and by First Nations governments.***

8. *Quality child care to First Nations has a special meaning. Involvement of Elders and respect for language and traditional values are essential components in achieving quality care. There is a need to protect and redevelop the traditional aspect of child care, particularly due to the "mission school syndrome."*

9. *Child care services delivered in First Nations communities must be considered an evolving service subject to innovation and development. The key to a successful delivery is flexibility.*

10. *First Nations government jurisdiction, powers, responsibilities must be recognized in the federal government's approach to a cost-sharing agreement. It is the desire of First Nations to enter into agreements directly with the Minister in regard to First Nations child care.*

11. *First Nations have the inherent right to develop and control their own child care systems. First Nations should develop national minimum standards for First Nations child care as guidelines. Those guidelines must reflect First Nations values and traditions.*

12. *Funding should be available for First Nations child care programs. Any funding should be at par with provincial funding. It must include money for start up costs, program implementation, as well as, capital for construction and building maintenance and for upgrading currently substandard facilities.*

13. *First Nations institutes must be given the funds to research and develop new approaches to First Nation child care based on First Nation traditions and values, as an alternative to existing Early Childhood Education programs. Theory and practice must be culturally sensitive and culturally appropriate.*

14. *Training for caregivers must enable them to examine family problems and dynamics as well as each child's physical and developmental needs. Caregivers should be trained to identify and help children with dysfunctional or abusive parents.*

15. *Poverty, abuse and alcoholism have created a large pool of "special needs" children who need comprehensive care. Caregivers must be trained to deal with these children in a culturally appropriate manner.*

16. Programs for children should include parents; they should offer instruction in parenting skills as well as rehabilitation counseling for parents who need treatment.

17. Programs must promote cross-cultural awareness.

18. Special needs children of impoverished and dysfunctional families should have equal priority with children of working parents in child-care programs.

19. Urban First Nation children have the same cultural, educational, physical and emotional needs as their on-reserve relatives. Funding for First Nation child care must be made available in urban areas.

20. The strongest recommendation (of the Inquiry) is that there be constitutional recognition and protection of our right to control our lives and our land. (p. 51-56)

The Historical Role of the Federal Government in Health, Education and Social Services

It is now 2001 and Canada still does not have a national policy or strategy for child care and early childhood development services. Regulated child care and most other early childhood services – like health, social services, elementary, secondary and post-secondary education – are all under provincial legislation. Each of Canada's 13 jurisdictions has a program of regulated child care (including nursery schools) that legislates requirements for operation of services, defines the operation of services and provides some funding arrangements. Provincial and territorial governments (with the exception of PEI) also provide separate public kindergartens under Ministries of Education. Historically the federal government has had no involvement in terms of funding or policy development in elementary or secondary education. Other early childhood services like Aboriginal Head Start and the Community Action Program for Children are under the auspices of, and funded by, the federal government (CRRU, 2001). The range of services and quality of services, as well as, families' access to them, however, varies significantly across Canada (see appendix 1) for an illustration of the number and kinds of early childhood programs by region.

Between 1984 and 1995 there were three significant attempts by the federal government to develop a national approach to child care. Three successive governments made attempts and each of these – the Task Force on Child Care set up by the Trudeau Government, the Special Committee on Childcare (Brian Mulroney), and the initiative based on Jean

Chretien's 1993 Red Book election commitment recognized the primacy of the provincial role in services like child care. For various reasons these efforts never produced ***a Canadian child care strategy or program***.

In the mid-1990's the federal government did introduce new services for "early childhood development" in the form of the ***Aboriginal Head Start Program*** which was targeted for early intervention and ***Community Action Programs*** for ***at risk*** children – both under the auspices of Health Canada. In 1999 The ***Aboriginal Head Start Program*** extended to on-reserve First Nations where previously it targeted off-reserve native organizations and groups. In 1995 the federal government also announced the ***First Nations/Inuit Child Care initiative*** to fund and establish child care programs in coordination with regional first Nations and Inuit groups. This was in addition to existing child care spending by DIAND and was budgeted as part of the $720 million over three years committed by the federal government (CRRC, 2001) following the 1993 election.

The major concern of First Nations in spite of these initiatives continues to be that services for children be ***culturally appropriate***, ***accessible*** and ***affordable***. Two major issues effect the ability of First Nations to make this goal a reality. ***That is the jurisdictional responsibility for Aboriginal child care services*** to the extent that the federal government and the provinces/territories have responsibility for the provision of social services generally (CRRC, 2001). The federal government as described previously interprets its responsibility as limited to ***status First Nations people living on a reserve***. It has further taken the position that the provinces and territories are responsible for ***off-reserve First Nations people and the Metis***. The provinces and territories maintain that section ***91(24) of the Act*** means that the federal government is responsible for ***all status First Nation people*** regardless of whether they live ***on or off-reserve***. This debate is further complicated by the fact that ***section 92 of the Constitution Act*** stipulates that provinces and territories are accountable for the development and delivery of 'welfare' services. This includes child care. The federal government argues that provincial/territorial law should apply to Aboriginal peoples as residents of the jurisdiction in question and that social welfare for all Aboriginal people is a provincial/territorial responsibility (CRRC, 2001). The National Inquiry into First Nations Child Care (1989) and the Royal Commission on Aboriginal Peoples (1996) have both pointed out over the years that this jurisdictional battle has been ***a major impediment*** on the development of child care services for Aboriginal children.

According to 1996 data the following children aged 0-14 identified with an Aboriginal group:

Table 3
Children 0-14 Years Identifying with an Aboriginal Group in Canada 1996

Age group	North American Indian	Metis	Inuit
0-4 yrs.	106,370	25,800	7,325
5-9 yrs.	101,415	24,220	7,025
10-14 yrs.	91,880	22,605	5,560

What Early Childhood Development Programs Ultimately Cost

The Aboriginal child population is significantly larger statistically than the national average making child care and early childhood development program services a ***critically important issue***. Aboriginal children continue to be under-represented in the current child care system. There have been initiatives in the 1990's that have addressed some of the need but clearly not enough. The following programs have been initiated to date:

Indian Affairs and Northern Development estimated expenditures since 1994 were:

- $15 million in 1994/95
- $17 million in 1995-96
- $18 million in 1996-97
- $18 million in 1997-98

National Child Benefit

- 1998-99 $30.3 million
- 1999-2000 $48.26 million
- 2000-2001 $55.19 million

In 1998-99 the breakdown of expenditures equaled approximately: for Child/Day care programs ($810,589.00), Nutrition programs ($4 million), Early child development programs ($389,238.00), Employment and Training programs ($4 million) and other related programs ($5.7 million).

First Nations Child and Family Services

- The FNCFS program was established in 1991 under Directive 20-1. By 1998 there were 91 full service agencies in operation and 14 new agencies in the developmental stages.
- The budget in 1997/1998 was $195 million (serving 359 First Nations across Canada)

Health Canada estimated expenditures for *Aboriginal Head Start* have been:

- ***Off-reserve Aboriginal head Start*** was originally announced in 1995 and funding for a 4 year period totaled $93.7 million: $25.7 million for 1995-96, $23 million for 1996-97 and $22.5 million respectively for 1997-98 and 1998-99
- ***Aboriginal Head Start On -Reserve*** was set at $100 million over 4 years beginning with $15 million in 1998-99, $33 million in 1999/2000, $27 million in 2000/2001 and $25 million per year ongoing.

Human Resources Development Canada estimated expenditures for First Nations/Inuit Child Care have been:

- The ***First Nations /Inuit Child Care Initiative*** was announced in 1995. It intended to achieve levels of quality and quantity of child care in First Nations and Inuit communities that compared to the general population. The 3 year initiative 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.
- The financial commitment of $6 million was for 1995-96 which was followed by
- $26 million for 1996-97
- $40 million for 1997-98
- Ongoing funding of $36 million annually will be available thereafter.

In September 2000 Canada's First Ministers (except for Quebec's) announced an agreement on mainstream early childhood development services. The Ministers identified two objectives for this initiative (CRRC, 2000):

- ***To promote early childhood development so that, to their fullest potential, children will be physically and emotionally healthy, safe and secure, ready to learn and socially engaged and responsible.***

- ***To help children reach their potential and to help families support their children within strong communities***.

The Ministers' statement defined four areas to be developed to meet these objectives:

1. ***Healthy pregnancy, birth and infancy.***
2. ***Parenting and family supports.***
3. ***Early childhood development, learning and care.***
4. ***Community supports.***

Based on these announcements ***Campaign 2000*** interpreted the commitment to mean ensuring core services so that "***every child should be valued and have the opportunity to develop his or her unique physical, emotional, intellectual, spiritual and creative potential***." They calculated the actual cost of meeting this commitment and found that it would not be out of line with spending guidelines relating to children in other industrialized nations (CRRC, 2000).

Although ***Campaign 2000*** agreed with the objectives of the First Ministers' statement, they noted that they believed that attention was also required in the areas of **housing, employment** and **improved child benefits** which they noted are essential to truly improve children's life chances. The following is what they proposed:

1. Healthy Pregnancy, birth and infancy - $267 million

Healthy pregnancy, birth and infancy could be promoted by expanding and strengthening efforts to combat fetal alcohol syndrome and fetal alcohol effects (FAS/FAE) and by providing home visits to new mothers by public health. The cost of providing public health home visits for **each new birth** would add an $16.7 million annually (eg. in the year 2000 there were 334,000 births - multiply this times $50.00 for each home visit and this equals $16.7 million). Included in the formula also is the increased amount of $75 million over 3 years to expand the reach of ***Canada Prenatal Nutrition Programs*** increasing the total annual budget to $250 million.

2. Parenting and Family Supports - $1.7 billion

Services and activities to meet this need include: parent/child interaction programs, information and referral to resources and parenting education courses and workshops, toy and equipment lending programs, a parents “warm” line, support groups for families, short/long term counseling, supervised visiting programs, mediation, emergency and crisis intervention, outreach/home visiting, family violence programs and breastfeeding programs. The ***Canadian Association of Family Resource Programs*** calculates that a ***well designed family program*** providing basic support to 300 families would cost approximately $300,000 annually (costs would have to be adjusted to address urban and rural realities but this is an estimate). The cost of providing supports **for the 1.7 million families in Canada** with preschool aged children is calculated at $1.7 billion annually.

3. Early childhood Development, Learning and Care - $7.4 billion

Currently early childhood development, learning and care is provided through: regulated child care, kindergarten, nursery school, Head Start, etc. many of which parents cannot access because they are not provided holistically or universally. The calculated cost for a **publicly** funded early childhood development, learning and care system for **all 2-5 year olds** in Canada, ***with affordable parental fees***, would be $5.3 billion. Additionally extending maternity/paternal leave benefits to one year would permit more universal take-up, adding 1 to 2 years olds to the cost projections, netting another $2.1 billion, with a total projected cost of $7.4 billion.

4. Community Supports - $654 million

Community supports for early child development (ECD) would include infrastructure, new service models, community support and development and some training. The total cost of items 1-3 comes to approximately $9.3 billion and 7 percent of this figure is $654 million which is the percentage allowed for administration of school boards, for example, in Ontario (5%), plus an additional 2% for recognizing the ECD system in its infancy (2000).

The total estimate for implementing the ECD is about $10 billion annually. According to ***Campaign 2000*** that is one percent of Canada's GDP (which is $10 billion).

According to the ***Institute for Research on Public Policy*** (1997) there are several reasons why Canada should include child care/early childhood development services in their main social programs:

1. High quality child care/early childhood development programs promote the healthy development, safety and well-being of children ***regardless of parental work status***. As we have indicated, if preschool child care/early childhood development service is high quality it provides intellectual and social enhancement that persists into elementary school, establishing a foundation for later success. Healthy development in early years serves as a solid foundation for life-long good health and is the formation of a competent civil citizenry (1997).

2. Disadvantaged children who are less likely to succeed in schooling, and more likely to become involved in delinquent activities later on, ***benefit*** from child care/early childhood programs.

3. Child care supports parents both as workers and in their parenting roles, so children can benefit from reduction of poverty, reduced family stress, and competent parenting. Healthy social development of individuals and communities, and inclusive early childhood services will strengthen and promote equity among classes, levels of ability, racial and ethnic diversity, and over time, strengthen social solidarity.

4. Access to reliable child care allows parents, ***especially mothers***, to participate in the paid labour force, training and education.

Quality child care is critical to the development of children. Poor quality is shown to have negative effects on children – regardless of social class (1995). The effects of high or poor quality child care may be long lasting, therefore, it is important to ensure what ever care is given ***is the best***. High quality child care is best described as **sensitive, responsive, personal, developmentally appropriate, culturally appropriate** and **not custodial or "schooly**." Research shows that high quality child care is best characterized by:

- ***High adult to child ratios***
- ***Stable consistent caregiving***

- ***Small group sizes***
- ***Staff/caregivers who are well trained in early childhood education***
- ***Adequate health, safety and physical environment precautions***
- ***Decent wages and working conditions (including support and resources), and***
- ***Good workplace morale.***

Additionally, **regulation, ownership** (auspice) and **funding** are key contextual factors to the quality and success of child care programs.

Child care commonly has a range of definitions but generally it refers to ***the arrangements and education of children under the age of 12 outside their immediate and extended family and regular schooling*** (1991).

Regulated or "formal" child care includes:

- Programs for groups of children called "child care centres" or "day care centres" which may operate for full or long days, short or extended or unusual hours and may be located in residential communities, at or near workplaces, in schools or in other locations;
- Part-day programs which are sometimes called "nursery schools";
- Care for small groups of children in a home of a child care provider, operated either under the supervision of an agency, a municipality, or supervised directly by provincial or territorial government officials, usually called a "family day care home" or a "family day home";
- Programs for school aged children, which provide care ***outside school hours***, either before or after school, during school holidays or teacher's professional activity days.

Unregulated but government monitored programs include:

- Resource or drop-in programs to provide parents at home or other providers of child care (such as a nanny, a relative or a babysitter) with information, parenting and caregiving resources, toy lending, networking, socialization opportunities and occasional respite care for children;
- Short-term care for use in emergencies e.g. when a child is mildly ill, or when the regular caregiver is unavailable

- Care in the child's home e.g. care overnight for parents who work nights or long hours

Formal Programs which operate under a mandate other than child care include:

- Residential and day summer and holiday camps and programs
- Recreation programs
- After-school or after-four programs which are not regulated as child care.

Unregulated, informal child care includes:

- Care in an unrelated care-provider's or a relative's home which is not regulated by government
- Care in the child's own home by either a baby-sitter, a nanny, a relative or friend not regulated by government.

A comprehensive child care system normally would include:

- Child care centres which would operate for full, short or long days or extended or unusual hours, located in residential communities, at or near workplaces, in schools or in other locations; available on a full-time or part-time basis
- Part-day nursery school programs
- Family day care in the home of a child care provider
- Programs for school-aged children outside school hours, either before or after school, during school holidays or teacher's professional activity days
- Family resource programs which would offer parents at home or other providers of child care (like a nanny, a relative or a babysitter) information, parenting and caregivng resources, toy and equipment libraries, networking and social opportunities and occasional respite care for children
- Short-term care for use in emergencies
- Care arrangement in the child's own home in certain circumstances (1991)

The biggest problems associated with child care in Canada is **availability, affordability and quality**. Parents often cannot afford child care, **especially high quality child care**. This is particularly true for infant and toddlers who are labour intensive care. Also, unpredictable or seasonal, emergency and unusual hours of care are also hard to obtain or are unavailable in many communities (1991).

Policy Implications of Child Care and Early Child Development for First Nation Communities

According to the ***Royal Commission on Aboriginal Affairs Report*** (RCAP) "child care is as much an economic development as a social issue. Child care is an integral factor in an individual's road to self-reliance and in community economic development and health." The impact of inadequate or unavailable child care is felt by the whole family and the community. At the center of it all are the children - the men and women of the future."

Economic opportunity, education, training and employment are viewed by First Nations people as the key to the future. Each will give First Nations the ability to address the issues of their communities in the context of the outside world. They will also develop economies and provide job opportunities. Low levels of education found among Aboriginal people in First Nation communities leads to unnecessary and unavoidable losses of social and economic benefits, not only to our communities but also to Canada.

The symptoms of poverty are devastating to First Nation communities especially when reforms to reverse poverty's trend have been unsuccessful. Empowerment in any society requires its' people to be pro-active. First Nations communities are no different. Poverty has a telling way of making people reactive, not pro-active, resulting in high dependencies on social assistance that can lead to under-employment and unemployment. In addition there are many specific issues that create failure in many First Nations students and workers. To achieve long term sustainable communities policy makers would be wise to encourage and support education, training and entrepreneurial endeavors. Hand and hand with these initiatives are the support systems necessary to ensure success. This particularly relates to child care and early childhood development.

Quality of health, family characteristics, community support and prenatal conditions influence a child's readiness for school and for the future. It also influences the parents' ability to participate in a positive way in training or the work force.

First Nation communities need child care and early childhood development programs for a variety of reasons: to meet the needs of working or studying parents and also to develop culturally appropriate child care, early childhood development and family support services for their children, families and communities.

Next Steps and What is Required

Although there have been child care and early childhood development initiatives in place since the 1990's there are still many barriers to overcome. The programs in terms of resourcing far from meet the need as described in our analysis of First Nation community risk factors (see Tables 1-2 on pages 10-16). The following are some of the realities that still exist in First Nation communities today:

Day care, Child care and Head Start centres are expensive to operate and many communities do not have the facilities or funding to open or provide for these services. Establishing programs that integrate language, culture and traditions, as well as, modern community living takes time and money. In many First Nation communities these programs are still in the development phase due to lack of funding, trained personnel and facilities.

Funding for the design and development of First Nations specific child care, early childhood development and Head Start training programs and capacity building for community boards, directors and program managers is required. Inclusion of Elders and knowledgeable community members in the design, development and delivery of early childhood development, Head Start and child care programs is essential.

Enhancement and creation of new child care and early childhood development services over time is critical to ensure that location, hours, and types of community programs are flexible and meet the needs of parents and families. The current allocations of funding and child care spaces are totally inadequate. Allocation formulas must recognize and support the diversity of community program and resource needs. Funding allocations also must provide sufficient funding to keep parent fees at an affordable level for all parents. Fee schedules must be consistent with community practices and values.

First Nations and regions that receive other funding for child care spaces must not be penalized in such a manner that existing funding is reduced. Capital and operations and maintenance for day care facilities are grossly under funded. Reporting requirements need to be community oriented. Most importantly regular child care spaces are so severely under resourced that ***special needs*** children have almost no access to services.

We know that early childhood intervention creates and fosters healthier communities thus saving money in social spending long term. There is a critical need for the federal government to coordinate within its departments to ensure integration and pooling of resources for First Nation early childhood and child care programming. There is no long term commitment by the government to continue their children's initiatives long term. This has critical implications for the well being of First Nations children who are such a precious resource for the future in terms of development, empowerment and self sufficiency.

Needs of First Nations must be considered in terms of creating, sustaining and providing technical support for child care and early childhood development programs. This is translated into the following:

1. Stable and adequate funding that is fair and equitably distributed is required for the long term.

2. Licensing and monitoring of day care, child care and Head Start facilities must be within the jurisdiction of First Nations in order to respect self-government and self-sufficiency parameters of First Nations.

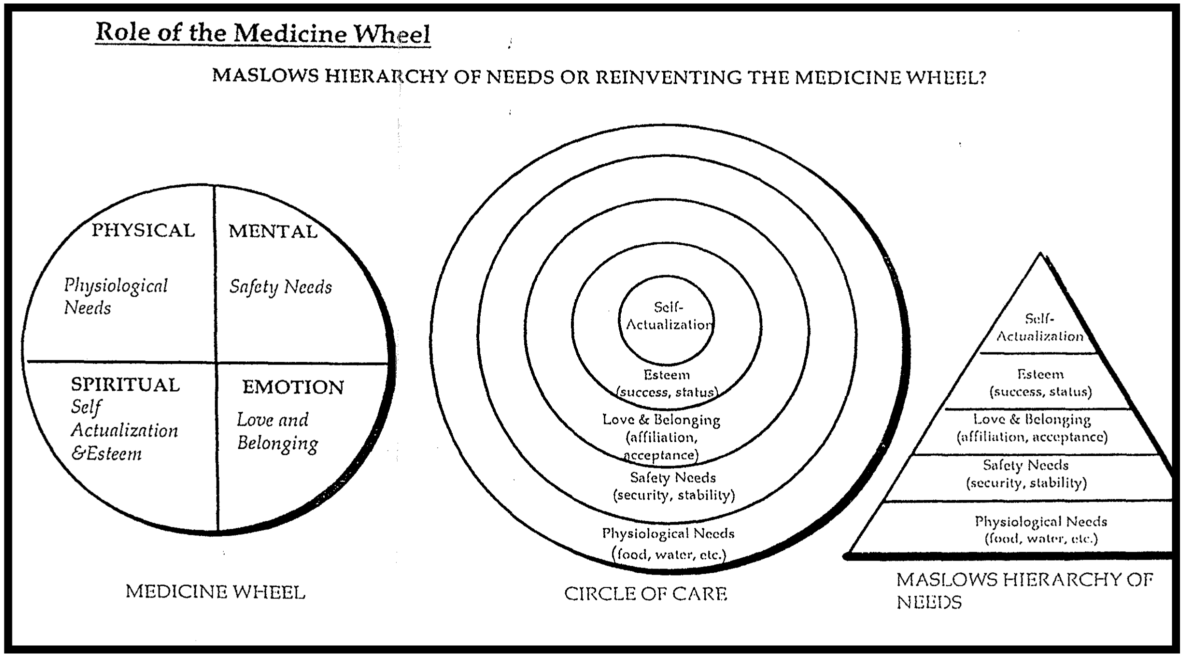
3. First Nation specific training must be developed and delivered to ensure there are sufficient child care providers who are able to meet the needs of First Nation children and their parents. Culturally specific curricula is also required.

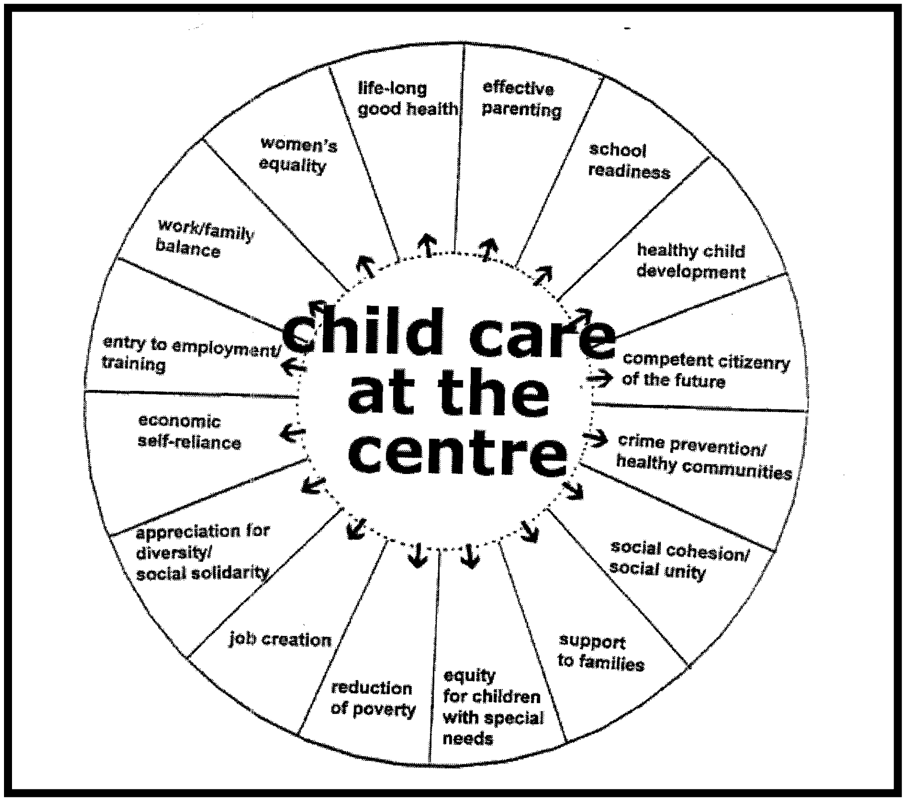
4. Resources are required for the development of proper facilities that also includes operation and maintenance costs for sustainability purposes. There is a severe lack of capital facilities.

5. Funding must be flexible and meet the diverse needs of regions and First Nation communities that are diverse and changing.

6. Resources are also required to meet the requirements of ***special needs*** children above that of regular child care spaces.

The following diagram outlines ***Maslow's hierarchy of needs*** and its relationship to the ***Medicine Wheel***. We know that for a human being to live they must have their basic physiological needs of food, water, housing and clothing met. They also must have their safety needs met in terms of security and stability. Love and belonging ensures acceptance and affiliation with the family, the community and ultimately society. With these an individual can develop their self-esteem, self-actualization and inevitably their full potential. For First Nations the majority of our population are still struggling with the vary basics of Maslow's hierarchy of needs. If their living, housing, food and clothing needs are not met then it will be impossible to achieve the higher levels of self-actualization that we all aspire to as human beings. This is the particularly the reality of First Nations children. It is our responsibility and the responsibility of Canada to have the political will to design and implement a national system of early childhood development and child care programs that will ultimately meet the true needs of First Nations people. This means programs that must be high quality, culturally appropriate, comprehensive, equitable, accessible and affordable. Any investment in our children will certainly be an ultimate investment in our future. **This is the right of our children and our people**.





Note: The Childcare framework illustrated here was developed by the Childcare Resource and Research Centre and is provided here as an illustration of a integrated approach to child care and early child development programming that addresses all the needs of children and their families.

Guiding Principles for Quality of Service for First Nations Child Care

Preamble

First Nations will ensure that there is a fair and equitable process for the distribution of resources to ensure quality programming that is defined as follows:

First Nations Directed and Controlled

Child care services and programs are designed, delivered and controlled by First Nations communities. First Nations have the inherent right and ultimate jurisdiction in this area.

Community Based, Holistic and Focused on Child Development

Child care services and programs reflect communities' cultural values, beliefs and traditions, and encompass a holistic approach to developing children's physical, mental emotional and spiritual being.

Quality of Service

Child care services and programs are of high quality and characterized by the following:

- **Child/staff ratios** - ensure the safety and care of children, while ensuring that staff have appropriate legal protection within a quality working environment;
- **Standards, regulations and licensing** - respect the children, the jurisdiction and cultures of First Nations communities;
- **Training** - staff are trained; the training is accredited and controlled by First Nations and is responsive and culturally sensitive to communities' cultures, languages and needs;

- **Environments -** ensure the safety and security, while fostering the physical and emotional health of children;

- **Administration -** of child care services and programs rests with First Nations communities;

- **Funding -** provides for a high level of quality child care services

- **Programming** - is designed and implemented by First Nations people for their children. Programming is based on First Nations cultural values, beliefs, traditions, languages, and services, to promote these in children;

- **Family and community involvement** - ensures that families of children served by child care programming are involved in the delivery of services and that other members of the community, such as extended family members and Elders are included in the provision of those services.

Inclusive, Comprehensive, Flexible

Child care services and programs are inclusive, comprehensive and flexible. Services and programs respond to the diverse needs of First Nations children and families by providing a wide range of services flexible in nature and structure.

Accessible

Parents working, learning or participating in traditional economies and other activities related to the economic goals of families and communities are provided accessible child care services at least comparable to child care services available to the general population.

Accountable

Child care services and programs are accountable to the children, families and communities they serve. Resources available from the Initiative are used for child care services. The program has a high profile in the community and other accountability processes in place include reporting, evaluation, standards, regulations and effective monitoring and management mechanisms, as well as, public education. First Nations communities will design their own program and financial accountability measures and processes. Financial accountability measures are recognized by established accounting methods.

Affordable

Child care services are affordable to all First Nations community members requiring care for their children.

Source: First Nations Position Paper on Child Care AFN 1998

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POPULATION PROJECTIONS 1991-2015
For First Nation Populations – A Demographic Profile

Canada's registered Indian population is projected to grow by approximately 379,000 persons within the next 25 years, from 511,000 in 1990 to 890,000, plus or minus 44,000 to 66,000 by 2015, depending on the growth scenario considered.

In 1990, the registered Indian population comprised 1.9% of Canada's total population; by 2015 this population would increase to 2.7%

The youth population (aged 0-17) would increase from 204,000 in 1990 to 277,000 in 2015.

The working age population (18-64) would double from 286,000 in 1990 to 666,000 in 2015.

Of the projected 890,000 Indians in 2015, some 484,000 will live on-reserve (54%) and about 406,000 off-reserve (46%), assuming the continuation of the recent slow decline in the on-reserve population (Statistics Canada 1993:1).

Canada's registered Indian population grew substantially during the last decade. The growth rate was almost five times that of the Canadian population. (Statistics Canada 1993:1).

The age distribution illustrates the case of a young demographic structure with a large proportion of children and a small proportion of elderly persons. Young people (age 0-17) make up about 40% of the Indian population while the labor force age group (age 18-64) accounted for 56% and the elderly (age 65+), only 4%.

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Appendix 1

On September 11, 2001 Canada's First Ministers (except for Quebec's) announced an agreement on early childhood development services (CRRU 2001). The Ministers identified two objectives for this initiative:

- To promote early childhood development so that, to their fullest potential, children will be physically and emotionally healthy, safe and secure, ready to learn and socially engaged and responsible.
- To help children reach their potential and to help families support their children within strong communities.

The Minister's statement defines four areas to be developed to meet these objectives:

1. Healthy pregnancy, birth and infancy
2. Parenting and family supports
3. Early childhood development, learning and care; and
4. Community supports.

The following chart which is from the ***Childcare Resource and Research Unit*** presents the areas in which provinces and territories have allocated their ECD funds. It is based on provincial budgets for 2001-2002, news releases and feedback from provincial offices responsible for child care. It includes data available as of June 20, 2001. Information is updated as announcements are made. These data can be downloaded from the CRRU web site at the following address:

www.childcare.org/resources/CRRU/pubs/factsheets/ecd_chart