
# Making Early Years a Priority

**Nazeem Muhajarine,** PhD

Professor and Chair, Community Health and Epidemiology, University of Saskatchewan, Lead, Healthy Children Research Team, and Director, Saskatchewan Population Health and Evaluation Research Unit (SPHERU)

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Nazeem.Muhajarine@usask.ca www.kidskan.ca

# Key Messages (1)

- Early childhood is an extremely sensitive period in human development.
- Early adversity and later developmental health are linked through the development of brain systems regulating emotion, attention, self-control and stress.
- There is no single path from early adversity to poor developmental health;

# Key Messages (2)

- Specifically targeted, intensive and sustained services to break the cycle linking early adversity with negative outcomes.
- Credible evidence on how broader, community-level interventions might mitigate childhood adversities in ways that would improve long-term developmental outcomes still emerging.

# The world has changed

- About 75% of young children in Canada are in non-parental care on a regular basis
- In the past few decades, there has been a rapid increase in the number of mothers in the workforce, and attention paid to gender equity (Vanier Institute of the Family)
- Recent scientific evidence on the importance of brain development in the early years

**= the need for comprehensive public policy that meets the developmental needs of young children while at the same time, supporting parents' participation in the workforce or schooling**

# Intervention Research–SPHERU

- *KidsFirst* program, provincial evaluation
- Canada Prenatal Nutrition Program–impact evaluation
- Smart Cities, Healthy Kids
- SK Cognitive Disabilities Strategy and FASD Community Support programs
- Full-time, every-day kindergarten pilots
- [PHAC ECD best practice review]

# KidsFirst Intervention research questions

a) Did *KidsFirst* deliver the program in its intended content and to its intended audience?

b) Did *KidsFirst* produce measurable short-term changes among its participating families and children (health and developmental changes)?

c) How has *KidsFirst* produced these changes?

# Key findings

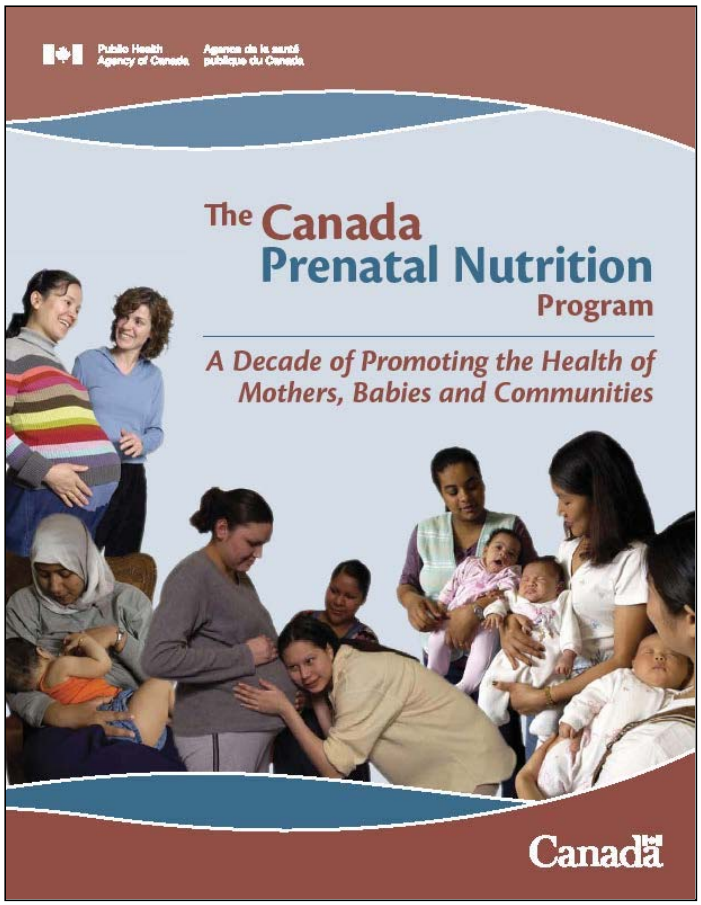
- *KidsFirst* helps ensure children in vulnerable circumstances nurtured by healthy, well-functioning families
- clients better served when *KidsFirst* collaborates with other agencies serving the same clients
- participants reported many had received services because of *KidsFirst*
- program struggles with staffing issues, capacity to serve complex needs families (those with cyclical crises)

# KidsFirst Recommendations

1. Intake should focus on increasing prenatal recruitment.
2. Increase the intensity of services provided for up to one year.
3. Parents should be encouraged to take their children for well-child visits within the first year.
4. Complex needs families should be offered a modified (specialized) program.

# Recommendations (2)

5. Complex needs families should be assigned to specialized home visitors.
6. Targeted area restrictions should be reviewed and updated or eliminated.
7. Children screened and referred to additional psycho-educational interventions should be followed through and their outcomes recorded.


Public Health Agency of Canada
Agence de la santé publique du Canada
The Canada Prenatal Nutrition Program
A Decade of Promoting the Health of Mothers, Babies and Communities
Canada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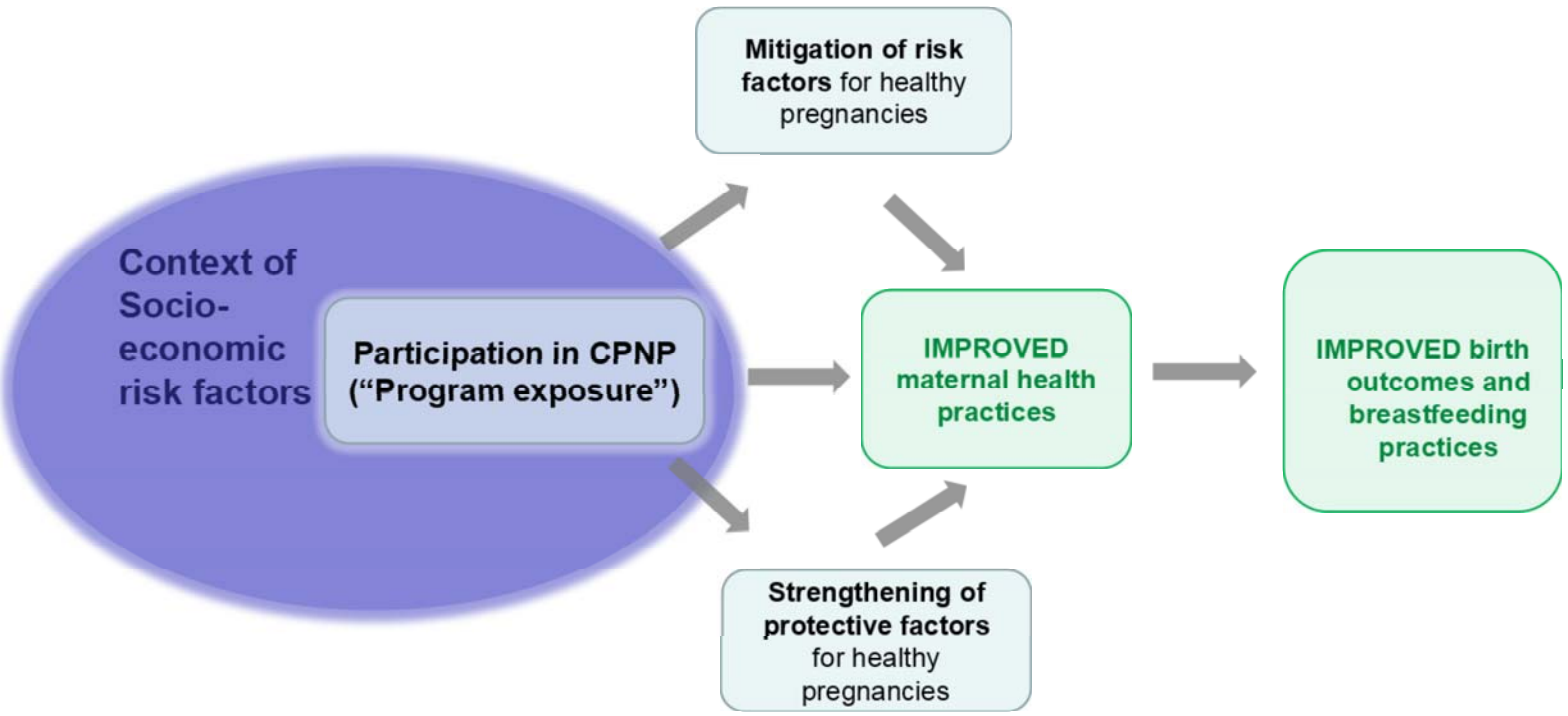
The Canada Prenatal Nutrition Program ♥ Overview
What is the Canada Prenatal Nutrition Program (CPNP)*?
For more than a decade, the CPNP has helped mobilize communities to promote public health and reduce health disparities affecting pregnant women and their infants. It is a federally funded program that is managed jointly with the provinces and territories, to allow for the identification of priorities and target groups, reflecting each region's particular needs.
The CPNP funds community-based groups and coalitions to increase access to health and social supports for prenatal and recently postpartum women facing challenging circumstances that put their health and the health of their infants at risk. These circumstances include: poverty; teen pregnancy; social and geographic isolation; recent arrival to Canada; substance use; and family violence. CPNP projects also increase the availability of culturally sensitive prenatal support for Aboriginal women.
The program encompasses a comprehensive range of services, which may include: nutrition counselling; prenatal vitamins, food and food coupons; prenatal health and lifestyle counselling; breastfeeding education and support; food preparation training; education and support on infant care and child development; and referrals to other agencies and services.

# Logic diagram showing how CPNP may have an impact on outcomes for mothers and children



# CPNP Evaluation Questions

(1) Are higher levels of program exposure related to more positive changes in personal **health practices** among CPNP clients?

(2) Are higher levels of program exposure related to better **birth outcomes** among CPNP clients?

# Two secondary questions

(1) Is receiving particular CPNP services related to health practices and birth outcomes?

(2) Does the impact of the CPNP on birth outcomes vary across different subgroups of clients?

# CPNP findings

1. CPNP had a demonstrable positive impact on reducing unhealthy practices during pregnancy
2. CPNP had a demonstrable positive impact on reducing risk of poor birth outcomes
3. CPNP had a demonstrably strong positive impact on breastfeeding initiation and duration of breastfeeding.

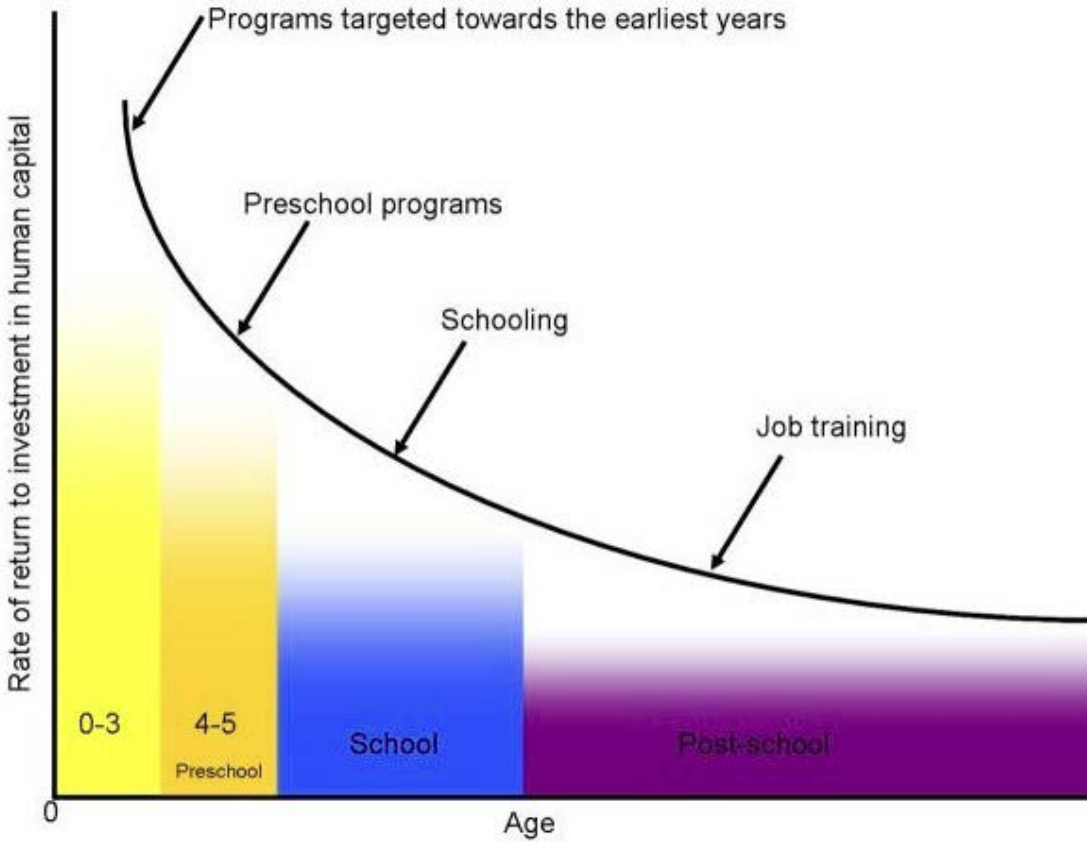
# CPNP findings (2)

4. In terms of specific CPNP services, group counselling seem to have a positive impact.
5. No real differences across subgroups of clients in CPNP's positive impact.
6. Surprise and caution: CPNP was associated with excess weight gain and large-for-gestational age babies.

# Pay now or pay more later

A sensitive period for intervention effects: decreasing return on investment with increasing age (**Pay now or pay more later**)

Heckman, 2008. Schools, Skills, and Synapses. *http://ftp.iza.org/dp3515.pdf.*



# Canadian Family Policy Assessment Tool

| INDICATOR | DEFINITION | PROGRESS ON INDICATOR | EVIDENCE* |
|---|---|---|---|
| ***Family time and resources*** | | | |
| **1. Family Leave** | 50 weeks of parental leave after child's birth (37 weeks for adoption), at 70% of average earnings (subject to upper and lower limits). Two weeks reserved for fathers. 10 days unpaid family leave. | *Province meeting/closest to meeting indicator*<br>Quebec: 50 weeks for birth/37 weeks for adoption, 75% of wages up to $62,000 for those with $2000 income previous year (more for low income earners). 5 weeks for fathers. 10 days family leave. | None mtg parental leave<br>BC: 5 days family leave<br>AB: no days specified<br>SK: 12days illness/injury<br>MB: 3 days family leave |
| **2. Child Poverty** | Provincial child poverty rate of less than 10% measured in LICO before taxes | *Province meeting/closest to meeting*<br>PEI: 10.2%*, Canada 14.8% (2008)<br>(*Statistics Canada advises use with caution due to small numbers) | BC 14.5% AB 10.5%<br>SK 15.6% MB 17.0% |
| ***Health, education and care services and supports in the community*** | | | |
| **3. Universal Outreach for Essential Health Services** | Meet at least two of these three indicators:<br>*Infant mortality less than 4 per 1000 live births (deaths at age less than 12 months per 1000 live births):<br>*Proportion of low birth weight babies less than 6 per 100 births (below 2500 grams/ 5.5 pounds)<br>*MMR immunization rate for two year olds more than 95% (1 or 2 doses based on province's immunization schedule at 24 months) | *Province meeting/closest to meeting*<br>Infant Mortality (2007):<br>Nova Scotia 3.3 Canada: 5.1<br>Low birth weight (2007):<br>New Brunswick: 4.9<br>Canada: 6<br>MMR Immunization rate:<br>Alberta : 91% (highest in 4 Western provinces, but based on 1 dose as per their immunization schedule) | Rate of infant mortality (2007)<br>BC 4 .0 AB 6.0<br>SK 5.8 MB 7.3<br>Low birth weight (2007):<br>BC 5.8 AB 6.6<br>SK 5.5 MB 5.6<br>MMR Immunization rate:<br>BC : 73.7% (2 doses, 2007)<br>AB: 91% (1 dose, 2004)<br>SK : 72.3% (SHR only; 2 doses; 1 dose 90%, 2004)<br>MB : 89.22% (1 dose, 2004) |
| **4. Access to ECEC services** | 40% of children 0-5 have access | *Province meeting/closest to meeting*<br>PEI at 41% , Quebec at 25% | BC: 18.3% AB: 17.4%<br>SK: 9.1% MB: 20.6% |
| **5. Staff Education and Training** | Minimum of 50% of staff have a minimum of 3 years post-secondary education in ECE. | *Province meeting/closest to meeting*<br>MB requires directors to have an ECE diploma, post-diploma continuing education certificate and 1 year experience; two thirds of staff working with 0-6 year olds must have ECE diploma | BC: 100% staff have 1 year of ECE training; additional training required depending on staff: child ratios, children's ages<br>AB: 25% 1 year ECE diploma; director 2 year diploma<br>SK: 30%: 1 year/ director 2 yrs<br>MB: 66%: 2 yr/ director more |
| **6. Staff to Child ratios in ECEC** | Minimum of 1 staff member per 10 children ages 3-5 (36 to 60 months) | *Province meeting/closest to meeting*<br>At 36 months all provinces except PEI and SK are 1:8 or lower. At 60 months NL and BC ratios are 1:8 | 36 months:<br>BC 1:8 AB 1:8<br>SK 1:10 MB 1:8<br>60 months:<br>BC 1:8 AB 1:10 |
| ***Public planning and monitoring (supports other two parts of framework)*** | | | |
| **7. Public Planning and Monitoring** | Province has developed a public plan to provide families with time, resources and access to high-quality community services, focus on vulnerable children; with targets, timelines, reporting | *Province meeting/closest to meeting*<br>Quebec has a comprehensive plan.<br>Manitoba: coordinated approach, 5-year planning cycle, focuses on vulnerability but no long-term comprehensive public plan. | None meeting |
| **8. Public Funding** | 0.6% of provincial GDP spent on Investment in ECEC for children less than 6 | Quebec at 0.61% followed by MB and ON at 0.36%; overall Canada outside Quebec spends 0.28% of GDP | BC 0.22% AB 0.10%<br>SK 0.18% MB 0.36% |

# Table 4: Canadian Family Policy Assessment Tool

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# Developing an ECD community of practice

**kidSKAN,** the **S**askatchewan **K**nowledge to **A**ction **N**etwork for Early Childhood Development

- *funded by Canadian Institutes of Health Research with a Knowledge to Action grant*

**Mandate:**

- To facilitate ECD stakeholder networking and knowledge sharing
- To facilitate appropriate policy and practice change
- To identify and facilitate new opportunities for collaborative research


- Interactive, web-based community to inform, connect between meetings (www.kidskan.ca)
- regularly post plain language reports, news, analysis, ECD events on site
- send out email newsletter 2x/month
- create, post videos to YouTube
- connect on Facebook, Twitter

# Conclusion

- Early intervention offers our province, our country a real opportunity to make lasting improvements in the lives of our children.
- Need to change culture/mindset from late intervention to early intervention.
- Strong leadership by all parties is required.
- New thinking and new relationships needed to advance an early years priority.

# Contact us

## Visit www.kidskan.ca
## www.spheru.ca

Nazeem Muhajarine, nazeem.muhajarine@usask.ca

Mike Chouinard, mike.Chouinard@usask.ca

# What's happening in Canada

- many countries have well established systems of early learning and care
- benefits include lower drop-out rates, decreased child poverty levels, enhanced maternal wellbeing, stronger communities
- Canada one of the few economically advanced countries with no comprehensive ECD strategy
- Several provinces have developed strategies, such as Quebec, BC, Manitoba, Ontario

# ECD research in Canada

- A great deal of interest in early childhood development research in Canada in the past 15 years; publication of Early Years Study: Reversing the Real Brain Drain, in 1999; follow-up Early Years Study 2 in 2007

- Growing interest in monitoring children's early development using the Early Development Instrument, a Canadian population-level tool

- Early Development Instrument is a "checklist" completed by kindergarten teachers, that measures young children's development in five areas: language and cognitive skills, physical health and wellbeing, social competence, emotional maturity, communication skills

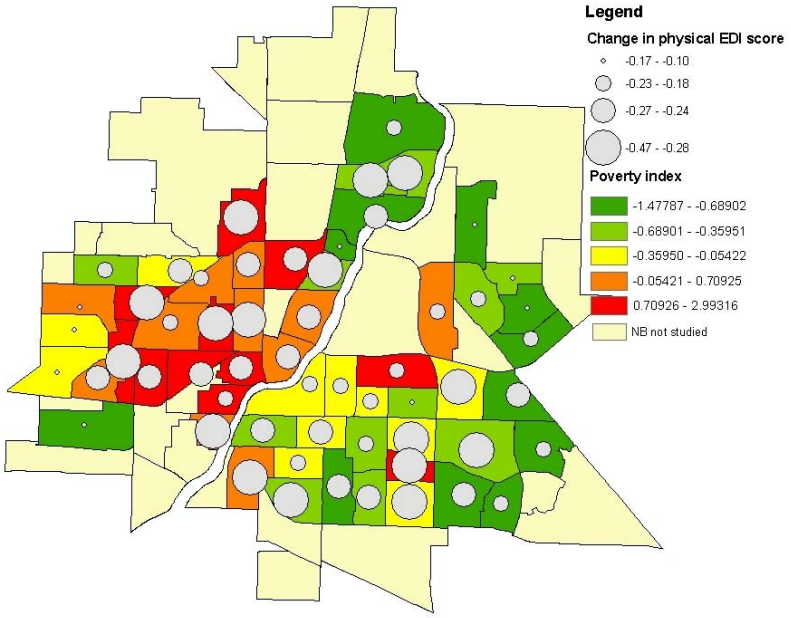

- EDI used in the Understanding the Early Years studies, of which almost 50 were conducted in Canada from 1999-2010
- 7 studies in Saskatchewan
  - Prince Albert (1999-2005), Saskatoon (2000-07), North East SK (2005-08), South East SK, Moose Jaw-South Central SK (2007-10), Regina (2007-2010), Prince Albert Grand Council (2007-11)
  - Saskatoon UEY project led to further partnerships, launch of kidSKAN, our provincial ECD community of practice

# EDI findings in Saskatchewan

- About 30% of young children were vulnerable (scores in lowest 10% compared to Canadian norm) in one or more EDI domains
- Domains of particular concern: language and cognitive skills, physical health and wellbeing, communication skills and general knowledge

# Findings from SPHERU research on EDI (1)

- EDI scores on Physical health, Communication skills decreased over time (6 years), but unevenly across neighbourhoods
- Single most important predictor of decreasing Physical health scores was neighbourhood level poverty

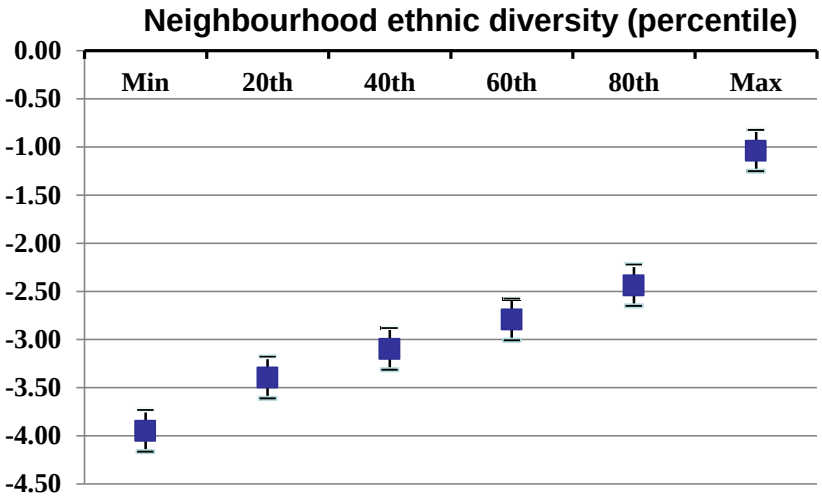



Cushon J, ….Muhajarine N. Neighborhood Poverty Impacts Children's Physical Health and Well-Being Over Time: Evidence From the Early Development Instrument. *Early Education & Development,* 22: 2,183-205.

# Findings from SPHERU research on EDI (2)

- EAL children significantly lower scores for all EDI domains
- Younger age, male, aboriginal status, special needs sig. related to lower readiness in communication skills and general knowledge
- Neighbourhood ethnic diversity mitigated negative impact of EAL status on school readiness
- EAL children from n'hoods with a high degree of ethnic diversity had higher EDI scores

Adjusted average difference in EDI Communication and general knowledge scores between EAL and non-EAL children by neighbourhood ethnic diversity



# Findings from SPHERU research on EDI (4)

- Implications: where children live—neighbourhoods, communities—matter in terms of developmental preparation for school
- Policies and programs should complement supports and resources at community level, promote inclusion and opportunities for families