Health Canada Santé Canada

Children and Youth Programs

Cluster Evaluation

Approved by

Senior Management Board
Finance, Evaluation and Accountability (SMB-FEA)
Health Canada

March 31, 2010

Canada

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CHILDREN AND YOUTH CLUSTER EVALUATION
2005/06-2007/08
MANAGEMENT ACTION PLAN

Recommendations	Actions	Responsible Manager	Planned Implementation Date
Recommendation #1: That Health Canada monitor new and emerging health needs for First Nations children and their families, including: • children with special needs and their families; • maternal mental wellness; • healthy nutrition and; • First Nations languages and culture.	• In collaboration with other partners (e.g. Assembly of First Nations, interested provinces and Indian and Northern Affairs Canada), CYD will develop strategies related to assessing and addressing gaps in health needs of Aboriginal women, children and their families including; o Children with special needs (including physical disabilities, mental health, children who have experienced abuse and/or neglect) o maternal mental wellness such as post-partum mood disorders and preventing alcohol consumption during pregnancy; o Healthy nutrition; and o AHSOR contributions to children's awareness and practice of their First Nations culture and language. • CYD will use this evidence to inform future development policy.	Director, Children and Youth Division (CYD), Community Programs Directorate (CPD), First Nations and Inuit Health Branch, FNIHB	June 2011
Recommendation #2: To effectively describe the continuum of programs, provide meaningful information on program outputs and outcomes and to support future evaluation and reporting, FNIHB needs to: • Assess the relationship with other program areas; • Review the reporting requirements and standardize the program activity reporting; • Identify gaps in programming; and • Identify where increased coordination would improve health outcomes.	• Update the "Program Compendium". • CYD will be taking part in a Branch wide 'renewal of authority' process that will update current logic models, related performance measurement strategies, a review of the Community Based Reporting Template (CBRT) and data holdings and will use findings from this evaluation to inform that process. • Gaps in programming will also be examined through the work identified in the response to recommendation 1. • CYD will develop and disseminate an interactive map displaying community/program reach which we will use to identify gaps and opportunities for increased coordination with other program areas.	Director, CYD, CPD, FNIHB Director, CYD, CPD and Director, Business Support and Capital Division (BSCD), Business Planning Management Directorate (BPMD), FNIHB Director, CYD, CPD, FNIHB Director, CYD, CPD, FNIHB	December 2010 March 2011 December 2011 March 2011

Recommendations	Actions	Responsible Manager	Planned Implementation Date
Recommendation #3: Resources and guides should be developed and/or updated to provide communities with the tools to identify, prioritize and address health needs.	• CYD will place an increased focus on knowledge translation – working with partners to develop tools and approaches to support communities (e.g., Planning and evaluation tools, conceptual models, best practices) to improve the continuum of programs and supports. • Branch health planning process will be revisited once authorities are renewed and changes will be made if needed.	Director, CYD, CPD, FNIHB Director, BSCD, BPMD, & Director, CYD, CPD & FNIHB	December 2011 October 2011
Recommendation #4 The CY Cluster Logic Model should be updated to clearly identify the outcomes for children and families.	• CYD will be taking part in a Branch wide 'renewal of authority' process that will update current logic models and related performance measurement strategies.	Director, CYD, CDP, and Director, BSCD, BPMD, FNIHB	March 2011
Recommendation #5: A training and capacity building strategy should be developed to address issues such as: planning and communication, supporting the development of culturally appropriate, standardized and accredited training, and recruitment and retention.	• CYD will develop a training strategy which will build on evidence from the Training Review and the ECD Horizontal Training Strategy. • CYD will continue to link with other areas in FNIHB that are engaged in training, recruitment and retention to inform its work in this area.	Director, CYD,CPD, FNIHB Director, CYD, CPD, FNIHB	March 2011 Ongoing
Recommendation #6: Tools to monitor the effectiveness and impact of training on workers and communities, as well as mechanisms to share best practices, should be developed**.**	• As part of the training strategy, CYD will also develop tools to assess the effectiveness of training and to help determine best practices and models. • CYD will share best practices and models of training with regions and communities to develop capacity and identify training needs.	Director, CYD, CPD, FNIHB Director, CYD, CPD, FNIHB	June 2011 December 2011

Health Canada Santé Canada

CHILDREN AND YOUTH PROGRAMS

CLUSTER EVALUATION

Aboriginal Head Start On-Reserve
Canada Prenatal Nutrition Program
Fetal Alcohol Spectrum Disorder
Maternal Child Health

Final Evaluation Report

30 October 2009

Canada

Presented by:
Auguste Solutions & Associates Inc.
Patricia Streich and Auguste Barrieau

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EXECUTIVE SUMMARY

This first cluster-based evaluation of Children and Youth (CY) programs of the First Nations and Inuit Health Branch (FNIHB) conducted between November 2008 and October 2009, examined the relevance and effectiveness of the CY Cluster in contributing to improving the health status of First Nations children, youth, and their families.

FNIHB national and regional offices contributed to the evaluation, as did 37 First Nations communities that were included in the site visits.

Overall, the evaluation concluded that the CY programs as a cluster (group) are relevant and effective in contributing to improving the health of First Nations children when they and their families participated in the programs.

Recommendations for improvements are provided.

PURPOSE AND SCOPE OF EVALUATION

The purpose of the evaluation is to respond to the requirements of the Federal Accountability Act, and to support FNIHB submissions for funding renewal in 2010. The CY Cluster includes four programs:

- Aboriginal Head Start On-Reserve (AHSOR);
- Canada Prenatal Nutrition Program (CPNP);
- Fetal Alcohol Spectrum Disorder (FASD); and
- Maternal Child Health (MCH).

The scope of the evaluation included all First Nations communities, located south of the 60th parallel, that receive FNIHB CY funding. The evaluation focused on the three-year time period from 2005/06 to 2007/08, although subsequent changes in FNIHB policies were noted.

CLUSTER-BASED EVALUATION AND METHODOLOGIES

In its 2005 renewal of program authorities, FNIHB grouped programs with common objectives into 'clusters of programs' including the Children and Youth cluster aimed at improving maternal and child health in First Nations communities. The purpose of creating the clusters was to promote a more strategic approach to services and supports in FNIHB's First Nations programming, including the planning, coordination and management of the programs within each of the clusters.

FNIHB has recently completed the *first cluster-based* evaluation of Children and Youth (CY) programs. The evaluation, conducted between November 2008 and October 2009, examined the relevance and effectiveness of the CY Cluster in contributing to improving the health status of First Nations children, youth, and communities.

This was the first cluster-based evaluation to be undertaken by FNIHB. As noted in FNIHB's CY Cluster Evaluation Framework (2008), the purpose of the cluster evaluation was *to capture commonalities among the programs and enable reporting of high level* (cluster-based) *results*.

The CY Cluster evaluation examined 3 relevance questions and 5 effectiveness questions. The evaluation's multi-methods approach included: (i) a literature review; (ii) a document review of existing statistical and program information; (iii) key informant interviews; (iv) surveys of FNIHB national and regional staff; (v) in-depth surveys of community program delivery staff and program participants in 37 First Nations communities; and (vi) site-visits to the 37 First Nations that were surveyed.

CONCLUSIONS

The findings and conclusions were based on information available at the time of the evaluation, and the data compiled in the study for the CY Cluster as a whole, and not for individual CY programs. Coverage of the CY program funding among First Nations varies, with approximately one-third of First Nations currently receiving funding for the full range of CY Cluster programs, while other First Nations receive funding for one, two or three of the four component programs. Evaluation findings take this factor into account and relate to the CY Cluster as a whole at the time of the evaluation.

R1. Does the CY Cluster address clearly identified health needs of FN children and youth?

Current health needs of young First Nations children include a wide range of significant disparities or 'gaps' as compared with other Canadian children. The existing literature and FNIHB documents have identified some health needs but others have not been measured due to lack of data. Perceived health needs vary by the age of the child. Trends in health needs over time indicate improvement on some health indicators (such as rates of breastfeeding and infant mortality rates). At the aggregate level, a key trend is the growing demand for programming related to the higher rate of population growth for First Nations as compared with the Canadian population. Some types of health needs are increasing more rapidly, and newly emerging health needs were also identified in the evaluation.

At the community level, the CY Cluster was rated as successful in meeting health needs by 35% of FNIHB staff and 70% of community staff, and some health needs in communities were better met than others. Prenatal care, preparing children for school, and dental health were most successful whereas First Nations languages, maternal mental wellness and, special needs were rated below average. Among people served by the CY Cluster, there is a high level of satisfaction with the services received.

The evaluation concluded that, at an overall Cluster level, the CY Cluster addresses identified community health needs of young First Nations children and their families. Key health issues requiring additional focus by CYD include: the promotion of First Nations languages, support for maternal mental wellness and, services for children with special needs and their families. In addition, there were gaps identified due to insufficient funding to provide all four children's cluster programs in all communities.

The findings also demonstrated the need to monitor new and emerging trends to ensure that programming remains relevant and key gaps are identified.

R2 To what extent is this cluster linked to a Government priority?

Since 2003, the overall rationale for the CY Cluster has related to the principles of investing 'upstream' to achieve improved health outcomes for First Nations and recognition of the importance of the early years in child development as a foundation for lifelong health and well-being. Key findings include:

- Since the late 1990's, successive federal government decisions and Budgets have expanded policies and funding available to provide services to First Nations children on-reserve that are available to other children living in similar geographic areas, and to develop and enhance a continuum of services for child health and well-being from prenatal stages to age 6; and

- More recently, the importance of the early years was recognized in the 2002 Federal Strategy on Early Childhood Development for First Nations and Other Aboriginal Children and a government decision in 2005 for enhancing early learning and child care for First Nations children living on-reserve.

The evaluation concluded that the CY Cluster is clearly linked to federal priorities to enhance the health and well-being of First Nations children living on-reserve, and is consistent with 1988 federal policy to transfer health services to First Nations control.

R3 To what extent is this cluster appropriate to the federal government and a core federal role?

Key findings related to the federal role include:

- Individual program components and the CY Cluster are consistent with the goal of the Indian Health Policy and federal roles in public health and health promotion; and

- As part of FNIHB's Community Programs, the CY Cluster contributes to the overall mandate of FNIHB in assisting First Nations to address health barriers and attain health levels comparable to other Canadians, by building strong partnerships with First Nations to improve the health system.

The evaluation concluded that the CY Cluster is appropriate to the federal government and a core federal role as well as consistent with trends toward First Nations health care delivery.

E1 Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?

CY programs and services have increased awareness and practice of healthy behaviours across a broad range of indicators, although areas for further improvement were identified. Further research would be required to quantify the capacity shortfalls to meet demand or to reach the intended target or eligible populations, to quantify the special needs problems and services required, and to investigate variations in awareness and practice of healthy behaviours among the various areas and for children at different ages. Key findings include the following.

- Participation rates in CY programs have increased in the past 5 years. However, the capacity of programs in the communities to further increase participation rates appears to be limited. Access to CY programs has improved in some communities over the past five years however, there are continuing barriers to access, and the **lack of services for children with special needs and their families** was identified as a key concern.

- The CY Cluster is moderately effective in providing quality programs. The services are highly rated by the program participants surveyed, and community delivery staff is experienced and qualified. Community staff face challenges in providing the amounts and depths of services to meet the health needs, most notably related to the staffing levels with the funding available in local communities.

- The CY programs and services have increased awareness of healthy behaviours across the broad range of indicators. Between one half and three-quarters of CY program participants surveyed said that they were much better informed as a result of the information they received from CY programs. There were slightly higher ratings on increased awareness of maternal prenatal care, breastfeeding and, physical activity for children than on **child nutrition and the importance of FN language and culture for children**. A major barrier to improving child nutrition was lack of adequate financial resources to cover the high cost of food.

- Practice of healthy behaviours by CY program participants has increased. Between one half and three-quarters of program participants surveyed said that they practice the healthy behaviours all or most of the time, and community staff also reported increased practice of these behaviours by the participants. The CY programming contributed to practice of healthy behaviours to a considerable extent, but more so for maternal health than for child development. **Reading with children and use of First Nations languages were identified as areas for further improvement**.

The evaluation concluded that the CY Cluster is effective in meeting health needs of program participants by increasing participation, and moderately effective in providing quality programs given staffing levels for program delivery. Areas that could be strengthened include: access to services for children with special needs and their families, support and information about child nutrition, and the incorporation and promotion of FN languages and cultures in CY programming.

E2 Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?

Overall, there is a continuum of programs in the CY Cluster to address maternal and child health needs for age 0 to 6 at the cluster program level. The continuum of programs is enhanced by networking and collaboration at all levels of FNIHB and in the communities.

Some areas for further improvement were identified as were constraints to increasing collaboration including:

- the continuum has improved in the past five years, however, there is insufficient funding to provide a continuum of services in all communities and to address all the health needs in many communities; and

- networking and collaboration are good and improving at all levels, with considerable collaboration both among the four CY programs and between the CY and non-CY programs at the community level.

The evaluation concluded that the CY Cluster provides an improved continuum of programs to address maternal and child health needs with positive networking and collaboration at all levels and in communities that are served by multiple programs.

E3 Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?

Unintended Outcomes Identified Principally by FNIHB Staff

A range of positive and negative outcomes from the CY Cluster were identified. With the data available, it is not possible to determine if the outcomes identified are localized or can be generalized to different regions, other communities and/or to all CY programs.

Delivery of CY programs at the community level fosters integrated approaches to services planning and more effective delivery. Positive outcomes include improved community awareness of their health needs and assets, supports the cluster-based approach to children's programming. At the same time, these trends tend to highlight resource and funding limitations, as well as service gaps and unmet health needs.

Participation in CY programs leads to a wide range of positive effects for parents and children that go beyond the focus on 'healthier behaviours' themselves. **These relate to broader outcomes for parenting, social functioning, and the overall well-being of children and families that are not currently identified as part of the CY Cluster logic model.**

CY programs are seen as fostering the inclusion of traditions and cultures into activities, and, in some cases, to have improved the reach of some services to women who may not have qualified for supports under previous programs. At the same time, interruptions of services (related to staff shortages or funding delays) have negative impacts on clients in need of support especially for those who may be 'in crisis' or have limited other resources to meet basic health needs.

Communities are strained to meet their health needs with existing resources. Despite dedicated staff and sharing of resources in many cases, it is challenging for communities to meet their health needs with the programs and funding available. Communities may not understand the basis for their funding allocations, and it was suggested that this can lead to tensions among communities.

Unintended Outcomes Identified Principally by Community Staff

The principal findings on **negative** unintended outcomes are:

- Concern about the potential impact of FNIHB's cluster approach and whether this will result in a reduction in funding; and
- Concern that the cluster-based approach will cause an increased demand for services that can not be met with current funding levels.

The evaluation identified the need for additional support on how to identify, prioritize and address health needs through structured integrated practices and guidance documentation. Moreover, the evaluation noted that the CY logic model was not designed to capture outcomes related to parenting, social functioning, and the overall well-being of children and families.

E4a Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?

The evaluation concluded that the increased involvement of First Nations in decisions about the CY programs can be expected to contribute to increased ownership of the programs and supports. The key finding from the evaluation was that **there has been increased involvement of First Nations in decisions about the programs** in the past 5 years.

E4b Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

The CY Training Review study found that training to support human resource capacity in CY Cluster programs is well aligned with identified needs. Many of the community respondents stated, however, that there was inadequate funding for training and that communication and planning on training could be

improved. The CY Training Review also found that children's program investments in training are contributing to increased human resource capacity.

SUMMARY OF CONCLUSIONS & RECOMMENDATIONS

The CY Cluster has made considerable progress in enhancing the framework for a continuum of services to promote healthy child growth and development. The conclusions and recommendations below are proposed with a view to the continuing development of measures to meet the health needs of First Nations children and their families.

1. Meeting the Health Needs of FN Children and their Families

- The evaluation concluded that, at an overall Cluster level, the CY Cluster addresses identified community health needs of young First Nations children and their families. Key health issues requiring additional focus by CYD include: the promotion of First Nations languages, support for maternal mental wellness, support and information about child nutrition and, services for children with special needs and their families.
- The findings also demonstrated the need to monitor new and emerging trends to ensure that programming remains relevant and key gaps are identified.

Recommendation #1:

- That Health Canada monitor new and emerging health needs for First Nations children and their families, including:
  - children with special needs and their families;
  - maternal mental wellness;
  - Healthy nutrition; and
  - First Nations languages and culture.

2. Collaboration and Networking

- The evaluation concluded that the CY Cluster provides an improved continuum of programs to address maternal and child health needs with positive networking and collaboration at all levels and in communities that are served by multiple programs. A more comprehensive assessment of the collaboration and networking is required to determine gaps in service and opportunities for increased collaboration.

Recommendation #2:

- To effectively describe the continuum of programs, provide meaningful information on program outputs and outcomes and to support future evaluation and reporting, FNIHB needs to:
  - Assess the relationship with other program areas;
  - Review the reporting requirements and standardize the program activity reporting;
  - Identify gaps in programming; and

- Identify where increased coordination would improve health outcomes.

3. Program Planning and Reporting

- The evaluation identified the need for additional support on how to identify, prioritize and address health needs through integrated practices and guidance documentation.

- Moreover, the evaluation noted that the CY logic model was not designed to capture outcomes related to parenting, social functioning, and the overall well-being of children and families. social functioning, and the overall well-being of children and families.

Recommendation #3:

- Resources and guides should be developed and/or updated to provide communities with the tools to identify and prioritize and address health needs.

Recommendation #4:

- The CY Cluster Logic Model should be updated to clearly identify the outcomes for children and families.

4. CY Training and Capacity Building

- The Training review concluded that overall training to support human resource capacity in CY programs is well aligned with identified needs however, communication and planning on training could be improved.

Recommendation #5:

- A training and capacity building strategy should be developed to address issues such as: planning and communication, supporting the development of culturally appropriate, standardized and accredited training and recruitment and retention.

Recommendation #6:

- Tools to monitor the effectiveness and impact of training on workers and communities, as well as mechanisms to share best practices, should be developed.

Section 1. INTRODUCTION

This Section: (i) provides an overview of the purpose and objectives of this evaluation of the four First Nations & Inuit Health Branch (FNIHB) programs included within the Children and Youth (CY) Cluster; (ii) introduces the concept of clusters within FNIHB; (iii) introduces the evaluation issues and evaluation questions that were addressed during the evaluation; (iv) identifies the First Nations communities that participated in the evaluation; and provides a list of the acronyms used in this report.

The four programs within the CY cluster are:

- Aboriginal Head Start On-Reserve (AHSOR);
- Canada Prenatal Nutrition Program (CPNP) (the First Nations & Inuit Component);
- Fetal Alcohol Spectrum Disorder Program (FASD); and
- Maternal Child Health (MCH) Program.

For purposes of this evaluation study, FNIHB has defined:

- Health needs as the conditions necessary for healthy child growth and development as measured by outcome indicators of child health and well-being. [1]
- The health needs disparities of First Nations children as the health disparities (gaps) between First Nations and other children in Canada. [2]

A Glossary of Terms is provided in Appendix 1. Terms included within that appendix are identified (the first time they appear) in this report with a blue underlined font; e.g. relevance.

1.1. Evaluation Objectives

The overall goal of the CY Cluster evaluation was 'to describe the relevance and effectiveness of the CY programs in contributing to an improved health status of First Nations children, youth and communities. [3]

The evaluation had two main objectives:

- Assess the relevance of the CY Cluster to the maternal and child health needs of First Nations and the link with Federal Government priorities and roles.
- Evaluate the effectiveness of the CY Cluster as a group of programs to achieve expected immediate and intermediate outcomes as identified in the CY Cluster logic model contained in the CY Cluster Evaluation Framework (2008) and the CY Cluster Result-Based Management and Accountability Framework (RMAF) (2006).

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[1] This approach is based on the reporting framework under Federal Provincial Territorial Early Childhood Development Agreements and reports on the well-being of Canada's children.

[2] A considerable volume of literature in Canada has documented the health disparities of First Nations children in terms of the 'gaps' in health outcomes as compared with other Canadian children. A health disparities approach is generally consistent with overall federal government policy on First Nations health that aims to narrow the 'gaps' between First Nations and other Canadian people.

[3] Health Canada, Request For Proposals, "2008-2009 Children and Youth Cluster Relevance/Effectiveness Evaluation", September 17, 2008, Page 3.

The Federal Accountability Act (FedAA),[4] which was enacted after the RMAF was approved, focuses on two evaluation issues, relevance and effectiveness. During the crosswalk exercise performed by FNIHB in 2009,[5] a greater focus was placed upon evaluation issues of relevance and effectiveness, and less on some of the areas previously identified within the RMAF.

The evaluation did *not* include a detailed assessment of funding models for FNIHB's Community Programs since a separate study of funding models was being considered. The evaluation did not examine human resources and training, but the results of a separate CY Training Review are included within this report. [6]

The scope of the CY Cluster evaluation includes all First Nations in the provinces south of the 60th parallel. Similar programs and services are provided north of the 60th parallel by the territorial governments under specific agreements with the federal government; and the evaluation of those programs is the responsibility of the three territories.

1.1.1. Similar But Different From Program Evaluations

This is the first cluster evaluation to be undertaken by FNIHB. While this cluster evaluation employs the methodologies and rigour of program evaluations, as well as the structure of evaluation issues and evaluation questions used in program evaluations, the cluster evaluation's scope is quite different.

FNIHB's CY Evaluation Framework (2008) states that the scope of the cluster evaluation is: (i) to capture commonalities among programs; and, (ii) to enable reporting of high level results. [7] The Framework also states that this evaluation *is not* intended to evaluate or measure the results of the four individual programs in the CY cluster, but rather to examine the contribution of the services and supports as a group.

Some of the cluster evaluation questions address desired behavioural changes being sought by one or more of the CY programs. However, the behavioural changes will not be identified as being the result(s) of one or more of the CY programs. For example, the cluster evaluation has examined whether CY programming has increased the level and duration of breastfeeding in First Nations communities; the desired behavioural change.

1.1.2. Timeframe Covered by the Evaluation

This evaluation examined and reports on the CY Cluster for the period 2005/06 through to 2007/08. In a small number of instances, the findings presented within this report are somewhat outdated because since 2007/08 FNIHB has made some changes to its policies, procedures and practices. When this has happened, a footnote has been included identifying the changes and, where needed, explained the impact this has had on the stated finding. The conclusions and recommendations take into consideration the identified changes made by FNIHB since 2008/09.

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4 The 2006 Federal Accountability Act legislates that: Subject to and except as otherwise provided in any directives issued by the TB, every department shall conduct a review [evaluation] every five years of the relevance and effectiveness of each ongoing program for which it is responsible.

5 The evaluation framework was revised as a result of the crosswalk exercise conducted by FNIHB between January 2009 and April 2009. This is discussed in Section 3 of the report.

6 The training information presented in the FNIHB report was not cross validated during the evaluation.

7 FNIHB, CY Cluster Evaluation Framework, June 2008, Page 15.

1.2. Evaluation Issues and Evaluation Questions

The evaluation issues, evaluation questions, and performance indicators are detailed in the CY Cluster's Results-based Management and Accountability Framework (RMAF) and its accompanying logic model. [8] During the first phase of the evaluation, the evaluation questions and performance indicators were revised to focus more on the cluster of programs and less on the individual programs. From the revised evaluation questions and performance indicators, evaluation sub-questions were produced.

The evaluation issues and evaluation questions employed in the conduct of this evaluation are presented in Table 1. The evaluation sub-questions are presented and addressed in Section 3 of this report.

Table 1: Evaluation Issues and Evaluation Questions

Evaluation Issues	Evaluation Questions	
Relevance	**R1.**	Does the CY Cluster address clearly identified health needs of FN children and youth?
	R2.	To what extent is this cluster linked to a Government priority?
	R3.	To what extent is this cluster appropriate to the federal government and a core federal role?
Effectiveness	**E1.**	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?
	E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?
	E3.	Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?
	E4a.	Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
	E4b.	Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

Note: Evaluation question E4b will be addressed using the findings from a separate study undertaken by FNIHB ("Children & Youth Division Training Review, 2009") on the capacity and training needs of First Nations to deliver child and youth programs in First Nations communities.

1.3. Acknowledgements and Participating Communities

FNIHB and the evaluation consultants would like to acknowledge the assistance of the two Tribal Councils and thirty-seven First Nations that participated in this evaluation. Community program staff and program participants (recipients) gave generously of their time to share their wisdom, knowledge and experiences with the CY programs. Without everyone's' contributions, this evaluation could not have been completed. The communities and tribal councils are:

[8] Health Canada, CY Cluster Results-Based Management & Accountability Framework (RMAF), 2006.

Atlantic Canada:
Annapolis Valley First Nation
Eel Ground First Nation
Elsipogtog First Nation
Millbrook First Nation
Québec:
Conseil de la Première Nation Wendake
Conseil des Innus de Pessamit
Listuguj Migmaq Government
Ontario:
Algonquins of Pikwakanagan
Aundeck-Omni-kaning First Nation
Chippewa of the Thames First Nation
Chippewas of Kettle & Stoney Point
Curve Lake First Nation
Delaware First Nation
Shawanaga First Nation
Wampole Island First Nation
Manitoba:
Fisher River First Nation
Keeseekoowenin First Nation
Long Plain First Nation
Peguis First Nation
Saskatchewan, Prince Albert Grand Council [9]
Cumberland House First Nation
Hatchet Lake First Nation
Little Red - Lac La Ronge First Nation
Little Red - Montreal Lake First Nation
Montreal Lake First Nation
Red Earth First Nation
Shoal Lake First Nation
Wahpeton First Nation
Saskatchewan, File Hills and Qu'Appelle Tribal Council [10]
Carry the Kettle First Nation
Little Black Bear First Nation
Muscowpetung First Nation
Nekaneet First Nation
Okanese First Nation
Pasqua First Nation

[9] All of the communities of the Prince Albert Grand Council were invited to a multi-community 'community visit' meeting. H1N1 meetings scheduled at the same time prevented many of the communities from participating. However all communities were provided with community staff and community participant questionnaires.

[10] See previous footnote.

Peepeekisis First Nation
Piapot First Nation
Standing Buffalo First Nation
Starblanket First Nation

Alberta:

Sampson Cree Nation
Tssu-Tina First Nation

British Columbia:

Cowichan First Nation
Esketemc First Nation
Tseshat (Nuu-chah-nulth) First Nation

1.4. Audience and Timing for the Evaluation

The CY Cluster evaluation was undertaken in 2008/09 to meet reporting requirements under the CY Cluster RMAF, and to address the 2006 Federal Accountability Act (FedAA) requirements that the relevance and effectiveness of all grant and contribution programs be reviewed on a five-year cycle. This evaluation contributes to FNIHB's commitment to report to Treasury Board Secretariat prior to the March 2010 expiry of the Terms and Conditions for the MCH Program and the enhancement funds provided for the AHSOR Program.

1.5. Additional Information/Context

Health Canada's CY Cluster Evaluation Framework (2008) states that the CY Cluster Evaluation will occur in *the midst of transition from program focussed reporting and evaluation to cluster level reporting and evaluation*. [11] This evaluation occurred prior to the availability of common cluster level reporting information, and the financial allocation of resources during the evaluation period was provided along program lines rather than as 'cluster funding'.

The CY Cluster Evaluation was conducted in accordance with the federal government's evaluation standards established by Treasury Board Secretariat, and to address additional principles identified by the FNIHB CY Evaluation Working Group (including stakeholder involvement, transparency, cultural relevance, utility, volunteers, and shared ownership). [12]

1.6. Outline of Report

The first three sections of this report provide the background and methodology for the evaluation study. Sections 4 to 10 of this report provide the findings on the evaluation questions and sub-questions, and Section 11 includes other findings not related to the evaluation questions. Section 12 summarizes the findings and conclusions of the evaluation, and recommendations are presented in Section 13.

A series of appendices are included to provide additional detailed technical and supporting information. The technical reports and working documents were submitted separately.

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[11] FNIHB, CY Cluster Evaluation Framework, June 2008, Page 16.

[12] FNIHB, CY Cluster Evaluation Framework, June 2008, Page 16.

1.7. Acronyms Used in this Report

The acronyms used in this report are:

AHSOR	Aboriginal Head Start On-Reserve, also known as the First Nations On-reserve Head Start Program
CPD	Community Programs Directorate
CPNP	Canada Prenatal Nutrition Program
CY	Children and Youth
CYD	Children and Youth Division
FASD	Fetal Alcohol Syndrome Disorder
FedAA	Federal Accountability Act
FN	First Nations [13]
FNIHB	First Nations and Inuit Health Branch
HC	Health Canada
MCH	Maternal Child Health
NIHB	Non-Insured Health Benefits Program
RMAF	Results-based Management and Accountability Framework

Section 2. BACKGROUND

This section includes an overview of the CY Cluster, the reach of cluster activities, expenditures, and the intended use of the evaluation's results.

2.1. Definition of a Cluster

For purposes of this evaluation, a 'cluster' is defined as *a group of programs, services and/or activities that share common objectives and expected outcomes.*

A cluster may provide enhanced opportunities for collaboration, coordination, and integration across component parts that contribute to the achievement of expected outcomes.

The development of the CY Cluster in 2004 is discussed in the Background Literature and Document Review. [14] The overall intent of creating the CY cluster of programs was to streamline and coordinate children's programming and develop a strategic approach to planning for and reporting on results.

[13] The abbreviation (FN) is used only in tables where space is limited.

[14] Evaluation of the CY Cluster, Background Literature and Document Review, 2009, Patricia Streich, Auguste Solutions & Associates Inc.

The four programs within the CY Cluster were created at different times to meet specific health needs. They provide complementary services and supports to a common target group (pregnant women and families and young children under the age of 6), and share common expected outcomes of improving maternal and child health outcomes. As well, the 'formal clustering' of CY services and activities both recognizes and encourages collaboration and integration. [15]

Within this definition of a cluster, any changes to the make-up of the cluster under the existing objectives and outcome expectations would not affect the definition of the CY cluster as a whole. (This means that programs, services and activities could be added to or subtracted from the mix without changing the concept of the CY Cluster and without affecting the ability to measure cluster outcomes.)

2.2. Implementation and Evolution of the Cluster-based Approach

The cluster-based approach is an ongoing process that is partially implemented at the national and regional levels of FNIHB. [16]

In its 2005 renewal of program authorities, FNIHB grouped programs with common objectives into 'clusters [17] of programs' including three clusters within its Community Programs Authority: (i) Children and Youth (the focus of this evaluation): (ii) Chronic Disease and Injury Prevention; and (iii) Mental Health and Addictions. The purpose of creating the clusters was to promote a more strategic approach to services and supports in FNIHB's First Nations programming, including the planning, coordination and management of the programs within each of the clusters.

2.2.1. CY Cluster Performance & Evaluation

The CY Cluster RMAF identifies the performance reporting and evaluation formats for reporting on results. The first Performance Report on the CY Cluster, approved in May 2009, [18] concluded that the CY Cluster was in 'transition'. [19] The Performance Report noted that, while programs within the Cluster have common goals, objectives and activities, and that strides have been made toward coordination across the Cluster, reporting on activities was on an individual program basis, which made it difficult to report on performance at a Cluster level. FNIHB implemented a cluster based reporting template in 2008/09 which communities are using as they renew their contribution agreements.

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15 See FNIHB, "Performance Report 2004/05 – 2006/07, CY Cluster", October 7, 2008, Page iii; and, Health Canada, Children & Youth RMAF, December 30, 2006.

16 Development of the cluster approach is discussed in Section 4.1.2.

17 The cluster approach is discussed in more detail in Section 4 of this report.

18 The CY Cluster RMAF requires that performance reports on activities and outputs are completed every three years based on the performance indicators included in the RMAF document. The May 2009 Performance Report covered three fiscal years, from 2004/05 to 2006/07. Performance reports examine activities and outputs but do not assess 'outcomes' which are assessed in evaluations (currently on a 5-year cycle).

19 FNIHB, "Performance Report 2004/05 – 2006/07, CY Cluster", October 7, 2008, Page vii.

2.3. Overview of CY Programs

The CY Cluster of FNIHB's Community Programs includes four programs aimed at improving maternal and child health in First Nations communities. Each of the four programs has specific objectives and sets of activities. [20] Table 2 summarizes the key aspects of the four CY programs.

Table 2: Summary of CY Cluster Programs [21]

Key Features	CPNP	AHSOR	FASD	MCH
Start Date	1999	1998	2002	2006
Program Delivery	Community health & social services providers	ECEs, community workers, administrators volunteers	Community workers, volunteers	Community health nurses & family visitors Health care, ECEs
Program Activities	1. Nutritional screening, education & counselling 2. Maternal nutrition 3. Breastfeeding promotion & support	1. Promotion of FN language & culture 2. Pre-school education 3. Health promotion & awareness 4. Nutrition 5. Social support 6. Parent & family involvement	1. Prevention of FASD affected births 2. Support children diagnosed with FASD & their families 3. Supports to at risk women & affected families 4. Education & awareness 5. Capacity building & training 6. Assessment & diagnosis	1. Screening & health assessment 2. Home visiting 3. Referral services & case management 4. Integrating culture into care (Long term support for families in need)
Primary Target group	Pregnant women, breastfeeding women & infants up to 12 months	Children up to 6 years of age	Pregnant, at-risk women	Pregnant women & new parents

As summarized in the table, the CY programs were introduced over the past twenty years, with CPNP and AHSOR being the most well-established (oldest) programs, and FASD and MCH being more recent. All of the programs are delivered by community staff. Some programs in some communities have used community volunteers to help deliver some aspects the programs.

2.3.1. Coverage of First Nations

FNIHB is involved with 596 of the 615 [22] (96.9%) First Nations south of the 60th parallel, and funds one or more CY programs in 546 of the 596 (91.6%) First Nations. [23]

CPNP is essentially a national (universal program), while the coverage of the other three CY programs is based upon regional agreements between FNIHB and First Nations and their regional organizations.

FNIHB does not state that the other non-CPNP CY Cluster programs (AHSOR, FASD and MCH) are universal programs. FNIHB funding of AHSOR, FASD and MCH is based upon available funding, with allocations provided to each region. FNIHB Regions have established practices that determine how funding is distributed within the region. Some regions fund all communities while other regions fund projects in specific communities. There was no common national practice prior to 2008.

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[20] For detailed program descriptions see: FN& I Health Program Compendium, FNIHB, March 2007

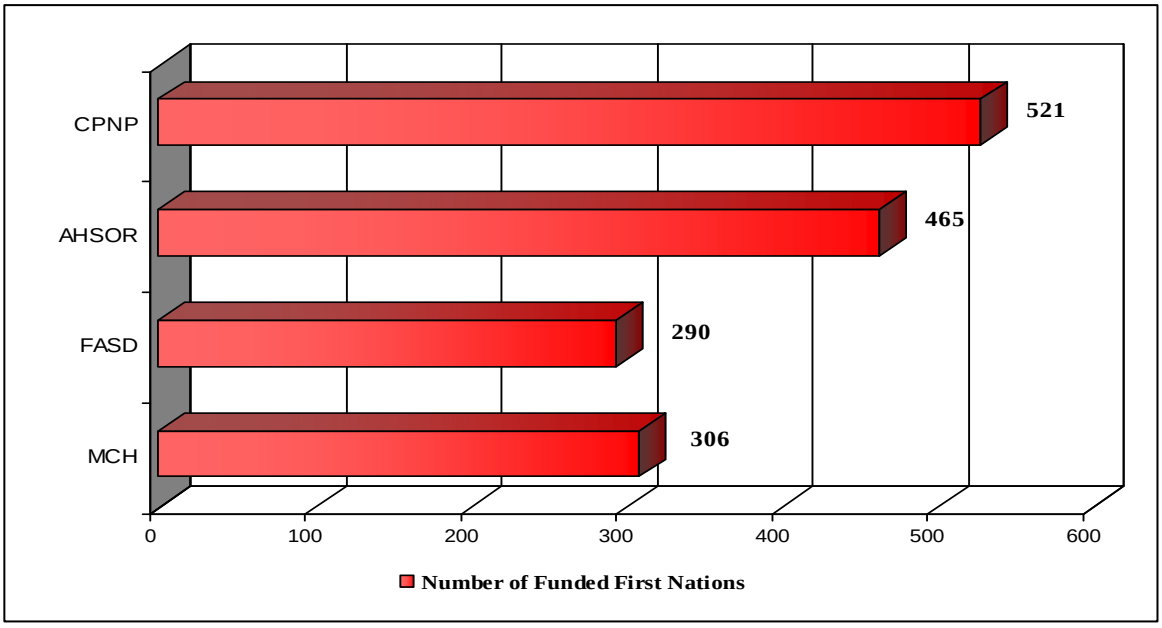
[21] Source: First Nations and Inuit Health Program Compendium, FNIHB, March 2007; Health Canada, Terms & Conditions for the Community Programs Authority, 2005; 2) FNIHB CY Cluster Performance Report 2004/05 – 2006/07, October 2008.

[22] Indian & Northern Affairs Canada (INAC) that recognizes 615 official First Nations located south of the 60th parallel. A few First Nations include multiple Registry Groups. The total number of First Nations by Registry Groups is 630. Information provided to CYD, FNIHB by INAC, March 2009).

[23] 2009 information provided by FNIHB regional offices lists 596 First Nations.

FNIHB's national and regional offices conducted an 'internal scan of programs' and compiled program reach information for the CY Cluster. Based on this information, which was only available for 2009, as shown in Figure 1: (i) CPNP is funded in 521 (87.4%) of First Nations; (ii) AHSOR in 465 [24] (78%) of First Nations; (iii) FASD in 290 (48.6%) of First Nations; and (iv) MCH in 306 (51.3%). It is noted that, in some cases, some elements of the CPNP services are funded by other means, and information may be distributed by staff in other programs. [25]

Figure 1
Coverage of First Nations (Calculated using 2009 Regional Information) [26]



Another measure of program coverage is the number of programs that are receiving CY funding in each community. As shown in Figure 2 (based on 2009 information provided by FNIHB's regional offices), 50 (8.4%) First Nations currently do not receive CY funding, [27] 49 (8.2%) receive funding for one program, 146 (24.5%) for two programs, 149 (25%) for three programs, and 202 (33.9%) First Nations are funded for all four CY programs. These two measures of CY Cluster programs and funding by First Nations indicate that, at current levels, there is insufficient CY funding to provide for full coverage of all CY programs to all First Nations communities.

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[24] In some regions, AHSOR funding may be provided for specific activities (such as summer camps or March break programs) and not cover full AHSOR programs.

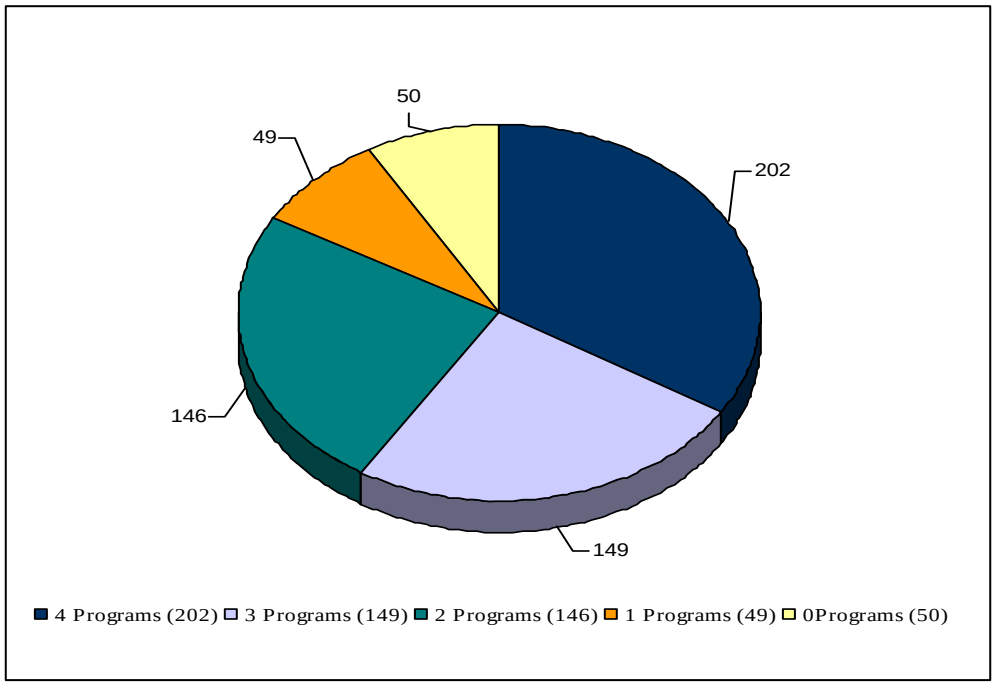
[25] For example, maternal vitamins may be funded through the Non-Insured Health Benefits (NIHB) and distributed by other program staff or through the health clinic. Where there are no specific FASD projects in communities, information about FASD can be provided by staff in other program areas.

[26] Source: Provided by FNIHB's offices. Information for previous years was not available.

[27] CYD does not directly fund CPNP in all First Nations. Some of the objectives of CPNP are covered by CY programs, Non-Insured Health Benefits funded by FNIHB, and social assistance which is funded by INAC. Current information does not confirm what percentage of these 50 communities may be receiving CPNP equivalent funding from other sources.

The distribution of CY programs by First Nations communities was considered in the evaluation methodology and selection of communities for site visits so as to ensure a cross-section of communities with different numbers of CY programs. [28]

Figure 2
Number of Communities by Number of CY Programs



Source: FNIHB Regional Offices, 2009

2.3.2. Program Funding in Transition

As of March 31, 2009, there were 732 contribution agreements with 580 individual First Nations and other organizations for funding of services under the CY Cluster, and 111 transfer agreements that included CY funding covering 215 communities. FNIHB has initiated a move away from funding one to four CY programs in each First Nations community, each with a separate contribution agreement. FNIHB is implementing a cluster-based funding model where First Nations would be funded for all CY programs within one contribution agreement.

This transition towards cluster-based funding is discussed in Section 6, Relevance to Federal Government Roles.

2.3.3. Reach to Program Participants

Estimating program reach to individuals is typically calculated based on the number of clients receiving services versus the number of eligible clients. It was not possible to calculate CY program reach because of the lack of accurate population statistics for First Nations and the lack of detailed program participant data. [29]

[28] See Section 3, Methodology for discussion of community selection.

[29] The 2008 CY Performance Report reported that more than 9,000 women participate annually in the CPNP, more than 9,000 children participated in AHSOR, and MCH provided home visiting to 2,221 families and referrals to 2,744 families.

Other challenges in assessing reach include definitions of 'eligible' clients. For example, in some cases, services may be provided to band members living off-reserve as well as those living on-reserve, and to non-band members living on-reserve. Program 'reach' is also related to the funding levels available overall and in the communities. If program funding is insufficient to meet total community health needs, communities may deliver their programs to a fixed number of participants and target assistance to higher 'risk' mothers or children. Some communities may deliver a more limited level of programming to a wider client group (such as all pregnant women or new mothers).

The CY Cluster is intended to provide a 'continuum' of services to meet expected results based on the logic model n the CY RMAF (see Appendix 2 logic model). Therefore, to estimate reach of the CY Cluster as a whole, it would be necessary to consider potential overlap between CPNP, MCH, AHSOR and FASD. There is currently no way of estimating the possible 'overlaps' among the mothers, children, and families who may have received or are receiving services across multiple programs over time. The 'continuum of services' is an aspect of the CY Cluster effectiveness considered in this evaluation.

2.4. Funding for CY Cluster

Funding for CY programs may be provided under one of four 'funding models': (i) set funding; (ii) transitional funding; (iii) flexible funding; and (iv) flexible transfer funding. Definitions of these funding models are provided in the Glossary (see Appendix 1). The four funding models vary with respect to the planning, accountability and reporting requirements. In-depth analysis of funding models was not included in the terms of reference for the CY Cluster evaluation, as a separate FNIHB study on funding arrangements was being considered. Table 3 outlines the planned and actual expenditures for CY Cluster Programs from fiscal years 2005/06-2008/09.

Table 3: Planned and Actual Expenditures for CY Cluster Programs (in millions of $s)

CY Children's Programs	2005/06		2006/07		2007/08		2008/09	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Aboriginal Head Start On-Reserve	54.02	51.13	57.32	52.52	59.72	54.42	59.02	50.58
Canada Prenatal Nutrition Program	14.15	9.54	14.15	9.89	14.15	11.02	14.15	11.20
Fetal Alcohol Spectrum Disorder *	17.72	15.86	17.72	16.03	17.72	17.29	17.65	20.04
Maternal Child Health	5.00	3.53	20.00	12.00	25.00	19.86	29.95	23.60
Total CY Cluster ($M)	90.89	80.06	109.19	90.44	116.59	102.59	120.77	105.42

Source: Financial Services, FNIHB, 2010

Planned and Actual include corporate, EBP and accommodations costs.

* Early Childhood Development Capacity Building financial information included in Fetal Alcohol Spectrum Disorder

However, the Report notes that data is based on the numbers of First Nations reporting and coverage is incomplete. Another variance is that "transferred bands are not required to report on the numbers of participants served by the programs they deliver".

2.5. Use of CY Cluster Evaluation Results

The CY Cluster Evaluation will be used by FNIHB to report to the federal government on the CY Cluster in response to Federal Accountability Act's requirement to evaluate the relevance and effectiveness of all contributions programs. [30] As well, the evaluation results will contribute to FNIHB submissions for funding renewal in 2010 for component CY programs.

The findings, conclusions and recommendations from this report will be used to create a management action plan towards improved programming and policy directions to better meet the needs of FN communities. It is also expected that: (i) the results will prove useful to the regional and community level offices for planning; and (ii) may assist in developing reporting frameworks under the CY Cluster.

2.6. Other CY Evaluations and Reviews

In the past few years, FNIHB has undertaken several evaluations and reviews of the individual CY programs as well as annual program reports, special studies and reviews. These evaluations and reviews have addressed the effectiveness of individual programs based on their objectives, and provided recommendations for program improvements. Recent examples include:

- ***Evaluation of the Aboriginal Head Start On-Reserve Program (AHSOR)***, 2004, a comprehensive two-year national process evaluation on the first five years of the AHSOR Program;
- ***Evaluation Report 2006 of the Canada Prenatal Nutrition Program – First Nations & Inuit Component (CPNP-FNIC)***, 2007, providing a summary and analysis of the results of numerous earlier evaluations and reviews;
- ***Maternal & Child Health (MCH) Program Implementation Review***, 2009 (forthcoming), a review of MCH in the first two years of the program introduced in 2006;
- CY Training Review, 2009; and
- FASD Mentoring Study, 2009.

On-going studies also include the *FASD Community Co-ordinator Study* and the *AHSOR Culture and Language Study* to be completed in 2010. Readers interested in more detailed information about individual programs are referred to these and other reports available from the CYD.

[30] The 2006 Federal Accountability Act legislates that: Subject to and except as otherwise provided in any directives issued by the TB, every department shall conduct a review [evaluation] every five years of the relevance and effectiveness of each ongoing program for which it is responsible.

Section 3. EVALUATION METHODOLOGIES AND CHALLENGES

This section includes a summary of the evaluation approach, detailed evaluation sub-questions, the methods used to address these questions, and a discussion of the limitations of the data. Methodological and other challenges are also identified.

3.1. CY Cluster Logic Model

According to the CY Cluster logic model developed by FNIHB (Appendix 2), the CY Cluster is expected to lead to improved delivery of quality, coordinated supports to mothers and young children and to increased awareness and practice of healthy behaviours. The long-term expected result is the 'improved health status of First Nations individuals, families and communities'.

Given that the CY Cluster includes activities introduced as recently as 2006 with MCH, it is noted that it would be too soon to evaluate the long-term results. Therefore, this CY Cluster Evaluation was intended to address the immediate and intermediate outcomes in the CY Cluster logic model. As noted in the Introduction, the scope of the CY Cluster Evaluation covers the 4 children's programs delivered in First Nations south of the 60th parallel from 2005/06 to 2007/08.

3.2. Evaluation Issues and Questions

The Health Canada Request for Proposals (2008) identified the two evaluation issues to be addressed (relevance and effectiveness) and eight evaluation questions identified in Table 1 (Section 1) of this report.

To provide more focus and direction to the cluster evaluation, FNIHB and the evaluators produced evaluation sub-questions, structured so that the answers to each of the sub-questions provides the information needed to answer the evaluation questions.

The evaluation sub-questions are presented in Table 4, on the following page, which presents all of the evaluation questions and their evaluation sub-questions.

3.3. Developing Common Indicators for Cluster Level Evaluation

The evaluation examined the evaluation sub-questions at the level of the CY Cluster as a whole, using common indicators across the four component programs. During the evaluation design phase, FNIHB's CYD and evaluation staff worked with the evaluation team to develop performance indicators based on the CY Cluster Logic Model and activities within the CY Cluster programming. A 'crosswalk' exercise was conducted to link the expected CY Cluster results to relevant common indicators for each of the evaluation sub-questions.

Table 4: Evaluation Sub-questions Identified

Evaluation Issues	Evaluation Questions	Evaluation Sub-questions
Relevance	**R1.** Does the CY Cluster address clearly identified health needs of FN children and youth?	**R1.1** What are the current health needs of FN children and youth? **R1.2** How have these health needs changed over time? **R1.3** Is there a clear link between the current health needs and the programs delivered by CY Cluster? **R1.4** Are the health needs, in the area of maternal and child health, being met? [31] **R1.5** Does the FN community staff, leadership and CY cluster partners/stakeholders believe that the programs delivered by the CY cluster are meeting the maternal and child health needs of their community?
	R2. To what extent is this cluster linked to a Government priority?	**R2.1** According to what Budget or other priority was this cluster (or programs within the cluster) created and what year? **R2.2** How does this program relate to current Government priorities and explain how its expected results are aligned to current Government priorities?
	R3. To what extent is this cluster appropriate to the federal government and a core federal role?	**R3.1** To what extent are the CY Cluster programs consistent with federal government roles & responsibilities to address FN health? **R3.2** Explain the nature of the federal government's role and mandate to deliver this program.
Effectiveness	**E1.** Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?	**E1.1** Has participation of FN individuals in programs and supports, relating to CY programming, increased? **E1.2** Has access to quality programs and supports, relating to CY programming, improved? **E1.3** Are the programs and supports, relating to CY programming, of quality? **E1.4** Has awareness of healthy behaviours related to CY programming increased in CY program participants? **E1.5** Has the practice of healthy behaviours, relating to CY programming increased among CY program participants?
	E2. Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?	**E2.1** Has the continuum of pre-natal to pre-school programs and supports in FN communities, relating to CY programming, improved? If so, how? **E2.2** Has collaboration and networking, relating to CY programming, increased and improved? If so, how?
	E3. Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster? [32]	**E3.1** Are there any unintended positive outcomes or impacts identified as a result of carrying out the CY Cluster? **E3.2** Are there any unintended negative outcomes, impacts or major concerns identified as a result of carrying out the CY Cluster?
	E4a. Does the grouping of the children's program investments contribute to increased FN ownership to deliver child health programs and supports?	**E4a.1** Has FN community ownership to deliver maternal and child health programs and supports increased?
	E4b. Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?	FNIHB identified nine evaluation sub-questions in the e-mail dated 18 Sept 2009; which were addressed in a separate review conducted by FNIHB. Section 10.2 of the report identifies those evaluation sub-questions, and presents FNIHB's findings and/or conclusions to those questions.

[31] Following discussions with FNIHB staff the original wording of this sub-question was revised to drop the wording 'of program participants', thus better reflecting the focus on relevance (rather than effectiveness).

[32] Specific sub-questions for E3 were not identified at the start of the evaluation. Sub-questions E3.1 and E3.2 were subsequently developed to add focus and maintain the structure of the analytical process.

A major challenge in this evaluation was to assess changes in 'healthy behaviours' and 'health status' linked to the CY Cluster. [33] Since this evaluation addresses the CY Cluster as a whole (rather than the four individual children's programs), common indicators of change were required for activities across the four programs. An additional challenge is to link indicators to CY Cluster activities since the literature has shown that many social and economic factors affect individual health outcomes.

Table 5: Common Indicators of Awareness & Practice of Healthy Behaviours for CY Cluster Evaluation

Area	Common Indicators
Maternal health (pre- and post-natal)	Prenatal care of mothers during pregnancy
	Healthy pre-& post-natal nutrition for mothers
	Mothers use of prenatal vitamins (including folic acid)
Child health & development	Breastfeeding for at least 9 months
	Mothers use of non-prescription drugs during pregnancy
	Mothers use of alcohol during pregnancy
	Healthy nutrition for children
	Physical activities for children
	Personal hygiene for children
	Knowledge of First Nations Language
	Involvement in cultural activities
	Verbal development (having discussions with children)
	Reading to children
	Music with children

Source: FNIHB CYD, CY Cluster Evaluation Crosswalk Tables, May 2009.

The selection of these common indicators was guided by existing research knowledge on First Nations maternal and child health and the range of CY activities. The indicators were further refined and tested during development of the survey tools, and Table 5 shows the list of 14 indicators adopted. The indicators are grouped into the two areas of maternal health and child health and development. The child health and development indicators cover areas of physical well-being, cultural and early development of verbal and language skills.

The evaluation methods were designed to measure increased knowledge about the importance of these factors as well as changes in the practice of these behaviours as related to information provided through CY Cluster services and supports. 'Increased knowledge' is considered to be a logical precursor to changes in the practice of specific behaviours. Since there are no pre-program baseline data, the evaluation measures changes based on the perceptions of program participants and service delivery staff.

[33] Evaluations term this link as 'attribution', that is, the extent to which changes can be shown to be related to the specific program services received as opposed to other factors.

3.4. Methods And Data Sources

The evaluation used a multi-methods approach that is recognized as a standard evaluation practice to improve the rigour of and confidence in evaluation findings. It combines the use of existing information with primary data collection to provide both quantitative and qualitative information on the evaluation sub-questions. Primary data collection included multiple perspectives on the effectiveness of the CY Cluster, that is, the program participants, community staff and FNIHB staff perspectives, to provide a balanced assessment. Three methods were used for examining existing information and four methods were used to gather primary data on the CY Cluster as follows:

- Literature and Documents Review
- Analysis of exiting statistical information
- Analysis of program administrative information
- Key informant interviews
- Survey of Participants in CY Cluster programs
- Survey of Community Staff delivering CY programs
- Survey of FNIHB National & Regional Office Staff

In addition, findings from the CY Training Review were summarized to address one of the evaluation sub-questions.

Each evaluation sub-question was examined based on information from two or more sources as shown in Table 6. The methods and data sources are grouped into three categories: existing data, primary data collection and other studies. The design of survey tools emphasized use of common questions to allow for comparison of findings across the different survey groups and to identify consistency of findings. The following Section of this report includes an overview of each of the methodologies.

Table 6: Summary of Data Sources by Evaluation Questions

Methods	Relevance									Effectiveness									
	R1					R2		R3		E1					E2		E3	E4a	E4b
	1.1	12	1.3	1.4	1.5	2.1	2.2	3.1	3.2	1.1	1.2	1.3	1.4	1.5	2.1	2.2	n/a	4a.1	n/a
Literature Review	X	X	X	X	X	X	X	X	X	X				X					
Statistical Analysis	X	X																	
Program Data			X	X						X									
Key Informant Interviews						X	X	X	X										
Participant Survey				X							X		X	X	X		X	X	
Community Staff Survey	X	X	X	X	X					X	X	X	X	X	X	X	X	X	
FNIHB Staff Survey	X	X	X	X	X					X	X	X		X	X	X	X	X	
Other studies																			X

Literature & Document Review: This in-depth review included close to 100 reports, papers and government documents on First Nations child health and general literature on child health and early childhood development. The primary focus was on more recent literature relevant to the evaluation period

(that is, since 2004), and was intended to address the relevance questions in this evaluation. The review examined data available on First Nations child health and other factors from the more recent, available 2004 First Nations Regional Health Survey (RHS). A separate report was prepared for FNIHB, and the key findings were integrated into this evaluation report. (A detailed bibliography is included in Appendix 3.)

Statistical & Program Data: The evaluation utilized existing data from the Census and Indian and Northern Affairs Canada (INAC) on population and socio-economic characteristics as well as community data for First Nations (by size, locations, and remoteness). FNIHB data on program budgets and expenditures, and program delivery by First Nations as well as the 2004/05 – 2007/08 CY Cluster Performance Report provided inputs to the design of the evaluation surveys.

Key Informant Interviews: In-depth, telephone interviews were conducted with three senior FNIHB officials to obtain background information on the development of the CY Cluster since 2004 and government roles in First Nation child health programming. Information from these interviews is incorporated into the report on the literature and document review for two of the relevance questions, and the key findings are included in this evaluation report.

Directors of Health and their department heads from the visited Tribal Councils and First Nations Communities were invited to participate in the community visits as part of the field work.

The Assembly of First Nations was contacted to obtain a national First Nations perspective, but due to staffing changes, they were unable to provide formal input within the time frame of this evaluation. However, the Assembly of First Nations has a representative on the Evaluation Advisory Committee, and they have followed the evaluation during its entirety.

Surveys of Participants, Community Staff & FNIHB Staff: Survey methods were used to obtain information on health needs and the effectiveness of the CY Cluster**.** There were two main elements:

- **Questionnaire surveys of CY Cluster participants and community, program delivery staff** in a sample of 37 First Nations communities. These surveys were completed through site visits and workshop meetings in 37 communities. The 37 communities included site visits in all Regions, small and larger sized First Nations in southern and more remote locations. All locations had two or more of the CY Cluster programs in addition to CPNP. (The detailed selection criteria are presented within Appendix 4.)

  Data was compiled with specially-designed workbooks to be completed during site visits. A primary focus of the workbooks was on the awareness and practice of healthy behaviours related to the expected outcomes of the CY Cluster Logic Model and the crosswalk exercise. The surveys were completed in 37 communities with 225 participants in CY Cluster programs and 118 community staff delivering the programs, services and supports. Key findings from these surveys are included in this evaluation report.

- **Questionnaire survey of FNIHB staff involved in children's programs in national and Regional offices** conducted by e-mail and telephone follow-up.[34] The main focus of this survey was on the relevance of the CY Cluster to health needs, access to a continuum of services, and networking/collaboration in children's programs. A total of 23 questionnaires were completed and key findings are included in this evaluation report.

[34] During the survey design, and given the specific nature of the questions about the CY Cluster, the scope of this survey was defined as persons sufficiently knowledgeable about the CY programs to provide meaningful information. Therefore, the original plan to include other key informants was revised in agreement with CYD, FNIHB.

All survey instruments in these 3 surveys emphasized use of structured questions to provide quantifiable data on specific evaluation sub-questions, and use of common questions across the three surveys to allow for comparisons of responses from the varying perspectives. Some open-ended questions were included to gather comments from respondents, and 'comments' were analysed by the evaluators to identify themes. This qualitative information is incorporated into this evaluation report to add interpretations to the numerical information. Separate technical reports with detailed data from these three surveys were provided to the Children & Youth Division (CYD), FNIHB.

Overall Analysis & Key Findings: Information from all of these methods was used in combination to assess the evaluation sub-questions. Consistencies of findings as well as variations in findings from the different methods are noted in this evaluation report.

3.5. Survey Respondent Profiles

The background characteristics of respondents in the three surveys are summarized below to identify their involvement with the CY programs. These profiles indicate that, in all three groups, surveys were completed with respondents covering all CY programs, and the majority had several years of experience with one or more of the CY services. This strengthens confidence in the quality and reliability of the survey data compiled, and that survey responses were obtained from knowledgeable respondents in each group. [35]

Program Participants: The typical respondent in the survey of CY program participants was a mother in her twenties with two young children. A small proportion, (14%) were young mothers under the age of 20. Respondents also included fathers or stepfathers or other caregivers (such as grandparents) who had children participating in programs.

There were a total of 547 children in the 225 families surveyed. Most of the families had one (34.5%) or two children (20.2%), 20.6% had 3 children, 13.9% had 4 children, and 9.4% had five or more children. Given the target groups for the various CY programs, the children were predominantly under age 6 (70%), but 30% of the families had children over age 6. There was a mix of ages from 17.2% under aged one, to 21% aged from 1 to 2, and 31% were aged 2 to 6.

At the time of the survey, nearly 41% of participants were enrolled in the AHSOR program; nearly 47% were receiving CPNP, 31% in the MCH programs and 6% in the FASD program. Nearly half of respondents (46%) said they were receiving services from more than one program.

Respondents had been receiving CY services and supports for a range of years. 31% had been using the programs for less than one year, 26% for 1-2 years, 19% for 3-5 years, and 24% for more than 5 years. The average length of time was 1 year and 9 months. These numbers reflect the family composition and that some mothers had had more than one pregnancy and have more than one child for whom they may have been receiving services.

Community Staff : Respondents in the survey of CY community staff (118 staff members) worked in all four of the programs with 45% working on CPNP, 48% on AHSOR, 44% on MCH, and 24% on FASD. Given program delivery arrangements and funding available, 62% of the community staff worked on more than one of the CY programs. About a third of the staff worked most of the time (over 75%) on one program, and a third worked less than half time on the program.

[35] Statistical information on survey respondents is included in Technical Reports submitted separately to FNIHB.

On average, the community staff had worked on the CY programs for about 5 years. About 25% had worked for less than 2 years, and nearly 20% had worked for 3 to 4 years on these programs. These data may under-represent the proportions of staff with fewer years of experience as the community staff were asked to invite members with more experience and knowledge on the programs.

Community staff have a wide range of professional qualifications for their positions, including: 23% in nursing, 10% in education, 30% in child care work, 15% in management or program administration, 7% in bookkeeping or accounting, and 8% in social work. A third of the staff had other types of qualifications, and nearly one-third had multiple qualifications or training.

FNIHB National & Regional Staff: In total, 23 staff from FNIHB national and regional offices responded to the survey, with 83% from the Regions and 17% from the national office in Ottawa. At the time of the survey, 19% worked in CPNP, 11% in ABSOR, 26% in MCH and 19% in FASD. However, 26% of the respondents worked in all 4 programs as they had management responsibilities for the CY Cluster as a whole.

Nearly 78% of respondents were in management or administration, 11% in policy or planning, and 7% in financial administration. Most of the staff (83%) worked full-time (over 75%) on the CY programs, but a few worked part-time or were in job-sharing situations.

On average, FNIHB staff had worked in the CY programs for 4-5 years (35%) or more than 5 years (31%). Nearly 22% had 1-2 years of experience in this area and 13% had worked less than a year in the CY Programs. As in the survey of community staff, these data may under-represent the proportions of staff with fewer years of experience as the survey was targeted to staff with more experience and knowledge on the programs.

3.6. Assumptions and Limitations

A key aspect of this evaluation was to use data from three perspectives as a means to reduce potential bias and improve reliability of the evaluation findings. FNIHB, community staff and the participants are the only groups in a position to provide *informed views* about the effects of the programs and services. Given the lack of pre-cluster baseline information for comparative analysis, the evaluation measures changes based on the perceptions of program participants and service delivery staff.

Addressing Potential 'Bias': Evaluations based on participant and staff viewpoints may have a tendency for biased results. When considering 'bias', there is a question about potentially offsetting biases, that is, whether or not there are both positive and negative biases which would cancel out in the final analysis. For example, positive bias (or favourable opinions) can arise if the recipients of the services have concerns, for example, that the service could be withdrawn; service providers and program managers may give positive responses if they have concerns, for example, about funding levels for their programs.

On the other hand, negative bias (that is giving low ratings or negative opinions) can arise if either or both participants and service providers have issues with the types of services provided. For example, participants may not receive all of the services they would like to receive and give low ratings to the services they do receive; service providers may perceive gaps in their services and give low ratings to their effectiveness. In communities where the need and demand for services are high and resources are limited, this latter bias is most likely to downwardly bias the results.

Representativeness of Survey Data: The ability to generalize to a wider population or area based on survey data depends on how the survey respondents are selected. There are two levels of representativeness in these evaluation data, namely, the coverage of First Nations and the coverage of program participants. [36]

The 37 communities include community of different sizes, locations, and the number of different CY programs being delivered in each community. Therefore, there can be some confidence that this selection covers a diversity of First Nations across Canada, even though it is not statistically representative of all First Nation communities.

This method of selecting participants does not provide a reliable, statistically-representative sample from which to generalize to all CY program participants in Canada. However, since there is no universe list of participants in CY Cluster programs, it would be impossible to construct a statistically representative sample of participants. This survey method includes a common issue with opinion-type surveys, namely, respondent 'recall', although it avoids other issues such as non-response bias and interpreting data with low survey response rates.

There are two major impacts of the above limitations on evaluation findings. First, the evaluation survey method provides data that is 'indicative' rather than statistically generalized data on all program participants. [37] This key limitation is noted in the presentation of survey findings. Secondly, comparisons of ratings from participants, community staff, and program managers are used to identify any significant differences in findings. Any differences are reported in this evaluation report, and taken into account in how the findings are reported. Areas requiring further investigation will be noted in the evaluation report.

3.7. Methodological Challenges

The major continuing challenge to evaluating the CYD's cluster-based approach (as defined by FNIHB) is that it does not evaluate the four CY programs to determine whether or not these individual programs are or are not achieving their intended results. Therefore, even if the cluster evaluation determines that the CY cluster (as a whole) is achieving its expected results, one or more of the individual CY programs may or may not be achieving its expected program results. Other studies may be required to assess individual elements of the CY cluster programming,

The other challenges faced in the CY Cluster are:

- The evaluation was intended to measure overall 'outcomes' of CY Cluster activities as identified in the CY Cluster logic model. Since this was the first cluster evaluation, the challenge was to develop relevant, high - level indicators and measurement tools across all elements of the activities;
- Some of the evaluation questions relate to the relationships among programs. It is difficult to assess how the component programs work together without pre-cluster baseline information;

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[36] It is noted that these data cannot be extrapolated to all First Nations communities but are illustrative of community staff and program participant views in the range of 37 communities covered in this evaluation study. Therefore, in all tables and figures, the data identified as from 'community staff' and 'program participants' should be taken to read as being from respondents to surveys in the 37 communities.

[37] The cost and time required to conduct the evaluation based upon a statistically significant number of communities, community staff, and participants would have increased the cost of the evaluation by about 50%, and would have lengthened the duration of the evaluation by another 4 to 6 months; a delay which would have negatively impacted on FY 2010/11 program funding.

- A cluster evaluation differs from a 'program' evaluation in that it measures outcomes of the 'cluster' as a whole, using common indicators rather than the outcomes of the individual programs; and
- It was difficult to evaluate integration, collaboration, and continuum as many of the communities did not deliver all four of the CY programs.

Section 4. RELEVANCE TO HEALTH NEEDS

This section presents the analysis and findings for the first of the eight evaluation questions.

Table 7: Evaluation Issues and Evaluation Questions

Evaluation Issues	Evaluation Questions	
Relevance	**R1.**	Does the CY Cluster address clearly identified health needs of FN children and youth?
	R2.	To what extent is this cluster linked to a Government priority?
	R3.	To what extent is this cluster appropriate to the federal government and a core federal role?
Effectiveness	**E1.**	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?
	E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?
	E3.	Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?
	E4a.	Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
	E4b.	Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

This section used the results of the evaluation's literature and document review and surveys to identify the health needs of First Nations children, and to determine whether the CY cluster of programs addresses the identified health needs.

For purposes of this evaluation study, FNIHB has defined:

Health needs as the conditions necessary for healthy child growth and development as measured by outcome indicators of child health and well-being. [38]

The health needs disparities of First Nations children as the health disparities (gaps) between First Nations and other children in Canada. [39]

[38] This approach is based on the reporting framework under Federal Provincial Territorial Early Childhood Development Agreements and reports on the well-being of Canada's children.

[39] A considerable volume of literature in Canada has documented the health disparities of First Nations children in terms of the 'gaps' in health outcomes as compared with other Canadian children. A health disparities approach is generally consistent with overall federal government policy on First Nations health that aims to narrow the 'gaps' between First Nations and other Canadian people.

As noted earlier in this report, the terms 'children and youth' are taken as referring to the target group for the CY Cluster, namely, children from birth up to age 6.

4.1. Current Health Needs (R1.1)

Table 8: Evaluation Sub-question R1.1

Evaluation Questions		Evaluation Sub-questions	
R1.	Does the CY Cluster address clearly identified health needs of FN children and youth?	**R1.1**	What are the current health needs of FN children and youth?

4.1.1. Health Needs Disparities of First Nations Children

For the purposes of this evaluation, FNIHB defined the *'Health needs disparities of First Nations children'* as the health disparities (gaps) between First Nations and other children in Canada.

4.1.2. Identifying Health Needs

Lacking an established list, health needs were identified by conducting a detailed literature review and undertaking a 'three-step approach' which includes identifying current health needs. [40]

Based on the literature and document review produced for this evaluation, [41] data analysis and surveys, there are substantial health disparities on many indicators of child health and development. However, the literature and document review did not identify any single summary of child health needs nor any ranking of the relative magnitude of the various specific health needs covered in the literature. Analysis of different sources in this evaluation provided a list of distinct health needs identified from different sources.

Quantifying current First Nations child health needs is challenging because of the lack of comparable data for both First Nations and other Canadian children. Furthermore, the CY Cluster of children's programs is just one group of measures dealing with aspects of child health and development, and the evaluation was not intended to cover other programs (such as primary health care, child care, child injury, and so on). Therefore, the evaluation needed to focus on the health needs related to the CY Cluster in particular.

To address these issues, a 3-step approach was taken in this evaluation study to identify current health needs as related to the CY Cluster, namely:

- **Step 1:** Identify types of 'health needs' based on the literature and document review;
- **Step 2:** Validate the 'health needs' based on surveys of community staff (who have first-hand knowledge of the health needs at the First Nations community level in the 37 communities visited), and of FNIHB program staff based on their experience with the CY programs; and
- **Step 3:** Quantify the 'health needs' based on available data and rank the health needs in order of magnitude.

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[40] There is no FNIHB approved list that identifies and defines the health needs to be addressed by the CY programs or the CY cluster of programs. It was therefore necessary to identify health needs for First Nations children. FNIHB does possess a series of internal reports and studies that addresses different dimensions of many health needs.

[41] See: 'Background Report on the Literature & Document Review", Report Prepared by Auguste Solutions & Associates Inc., for FNIHB, Health Canada, June 2009.

4.1.3. Step 1: Identify the Health Needs

Types of health needs were identified based on the literature review and discussed with FNIHB CYD and evaluation staff to assess their relevance to the CY Cluster for First Nations child health and development. [42] The indicators are discussed in detail in the Literature and Document Review completed for this evaluation.

Some indicators are related to specific health risks whereas others are outcome indicators or measures of the incidence of health conditions. In summary, they are defined (not ranked or prioritized) as follows:

- **Breastfeeding:** Breastfeeding for any period has been shown to have positive health benefits for children and the benefits increase with breastfeeding for at least 6 months. Therefore, children who are not breastfed at all and for at least 6 months may have elevated health risks.
- **Healthy child nutrition**: Eating balanced, nutritious meals has been shown to contribute to healthy child development. Therefore, children who do not regularly eat nutritious meals most of the time are at risk of impaired physical development and other health conditions.
- **Smoking during pregnancy**: While all of the effects are not well-defined, smoking during pregnancy has been associated with health risks for the fetus (such as lower birth weights). Therefore, the percentages of children exposed to smoking by mothers during pregnancy are an indicator of a health risk to young children.
- **Alcohol use during pregnancy**: Exposure to alcohol during pregnancy and 'binge' drinking (consuming 5 or more drinks on one occasion) have been associated with development of Fetal Alcohol Spectrum Disorder (FASD). Therefore, the percentages of children exposed to alcohol in vitro can be viewed as a potential health risk for children that can have lifelong effects.
- **FASD**: Fetal Alcohol Spectrum Disorder includes a complex range of physical and development effects which can be clinically diagnosed. Children suffering from FASD often require special support services to deal with the physical and other effects.
- **High birth weight**: While both low and high birth weights have been associated with increased health risks for children, reduced rates of low birth weight babies has focussed increased concerns on rates of high birth weight babies which have been associated with maternal health problems as well as potential health risks for the children later in life. Therefore, the percentage of high birth weight babies may be an indicator of health needs for improved maternal health care during pregnancy, as well as elevated health risks for the children.
- **Child injury**: Rates of child injury requiring medical treatment are indicators of physical health problems among children.
- **Verbal development and language, motor and social development**: Early childhood development studies have defined stages in many aspects of language verbal, motor, social and emotional development of young children. Positive development in the early years has been clearly shown to lead to more positive outcomes in later years. Therefore, the percentages of young children that are attaining the various stages of development are indicators of the learning well-being.
- **Hyperactivity:** Hyperactivity and the prevalence of diagnosable conditions such as Attention Deficit Hyperactivity Disorder (ADHD) are indicators of the extent to which children may

[42] It should be noted that these specific needs and indicators are used to provide a baseline measure of 'need' and have not been approved or adopted as part of FNIHB or government policy and program guidelines.

require additional treatment and other support services. Children experiencing these types of conditions often require additional supports to successfully develop motor, verbal, language and other skills in preparation for formal education. Therefore, the percentage of children with hyperactivity is an indicator of the need for additional development support.

- **Asthma, Bronchitis, & Ear infections:** Percentages of children experiencing these medical problems are direct measures of the incidence of the conditions, which if chronic and not adequately treated may lead to other, more serious health problems. These conditions require early diagnosis and treatment by a health professional.
- **Repeating grades in school:** Healthy early childhood development across the whole range of emotional, social, verbal/language skills, and so, promotes the early learning that prepares children for formal education when they enter school and enables them to progress through their education.
- **First Nations language**: The ability to speak and/or understand one's First Nations language has been closely associated with development of self and identity which relates to positive emotional and social development. Therefore, the percentage of children unable to speak/understand their First Nations language is an indicator of risks to positive early childhood development.

4.1.4. Step 2: Quantifying and Ranking Health Disparities

The second step was to measure the incidence of the health needs indicators for young First Nations and Canadian children from existing data sources. To the extent possible, comparable indicators were obtained from the most recent published data from the First Nations Regional Longitudinal Health Survey (2002/03) and the National Longitudinal Survey of Children and Youth (2002). The number of 0 to 5 year old First Nations children living on reserve lands south of the 60th parallel is estimated at 66,250. [43] [44]

Ranking was undertaken to identify the disparity (gap) between the percentages of First Nations children who have a specific health need, versus the percentage of Canadian children who have that that same health need.

The higher a health need is ranked, the greater the gap in the health need. In other words, the higher a health need is ranked, the greater (bigger) the disparity (gap) is between the percentages of First Nations versus the percentage of Canadian children who have the same health need.

Ranking one health need higher than another health need is not stating that one health need is more important than another health need. The ranking shows that there are greater numbers of individuals who need support for one health need, than there are individuals who need support for another health need. Table 9, for example, states that breastfeeding is ranked #1. This is not saying that breastfeeding is a more important health need than the other health needs in the table. By being ranked #1, breastfeeding has the greatest gap in First Nation communities and therefore offers direction for resources to improve/reduce this gap.

[43] The numbers of First Nations children ages 0 to 4 were provided by INAC as 53,000 (2008). In this table, the numbers of children have been estimated upwards to include children up to 5 years of age by multiplying the number for 0 to 4 by 25% (53,000 x 1.25 = 66,250 age 0 to 5). This was done to provide a better match with the CY Cluster programs.

[44] Statistics Canada information could not be used because many of the larger First Nations as well as many northern First Nations in central Canada did not participate in the last few censuses conducted by Statistics Canada.

Table 9: Ranking of First Nations Child Health Disparities (Children aged 0 to 5)

Ranked by Gap	Types of Health Needs	% Canada	% FN	% Gap	# FN Gap
1	Not breastfed at all	15.8%	36.5%	20.7%	13,714
2	Smoking by mothers during pregnancy	19.4%	36.6%	17.2%	11,395
3	Repeating grades in school	2.1%	18.0%	15.9%	10,534
4	High birth weight	13.1%	21.0%	7.9%	5,234
5	Child injury requiring medical treatment	10.0%	17.5%	7.5%	4,969
6	Poor language skills (verbal development)	13.1%	7.9%	5.2%	3,445
7	Asthma	9.4%	10.9%	1.6%	1,060
8	Bronchitis	1.4%	3.6%	2.2%	1,458

Source: See Background Literature & Document Review, ASA & Associates, 2009 for detailed data and sources.

The numeric information within Table is described as:

- **% Canada**: The percentage of Canadian children who have the specific health need;
- **% FN**: The percentage of First Nations children who have the specific health need;
- **% Gap**: The percentage of First Nations children who have the specific health need minus the percentage of Canadian children who have the same specific health need; and
- **# FN Gap**: The number of First Nations children is the gap multiplied by the total estimated number of First Nations children within the age group being evaluated.

The highest ranked health disparity is for breastfeeding. For example, 15.8% of Canadian women do not breastfeed their children, while 36.5% of First Nations women do not breastfeed their children. The gap between these two numbers is 20.7% (36.5% - 15.8%). At 20.7% this is the highest health gap identified by the evaluation, thus ranking breastfeeding as the #1 amongst all of the ranked health needs affecting an estimated 13,714 First Nations children aged 0 to 5.

Table 9 also shows the relative orders of magnitude of the health needs based on the numbers of First Nations children who experience the disparity. The right-hand column of the table shows the estimated number of First Nations children aged 0 to 5 who are affected by the specific health needs. (For example, more than 9 times as many First Nations children are affected by the lack of breastfeeding than are affected by the disparity on bronchitis rates.)

It is noted that, based on available data, reported hyperactivity rates for First Nations children are lower (2.6%) than the Canadian average (5.5%). Both of these statistics are based on parents' ratings of child hyperactivity and not necessarily on medical diagnoses of ADHD.

Some indicators are difficult to assess for other reasons. For instance, the rates of older children repeating grades in school (which the literature suggests is related to pre-school learning and school readiness) have been shown to be around 18% for First Nations children aged 6 to 11. Data for Canadian children from the NLSCY showed that a rate of 2.14% for children aged 8 to 15. Both the NLSCY and the FNRLHS data are based on parents' reporting of their children's school experiences.

In the non-First Nations education system there is currently a common practice called 'social promotion' [45] that results in low rates of repeating grades; the literature review did not identify whether social promotion is commonplace in First Nations schools, or not. Therefore, the numbers shown in the Table 9 may over-estimate the extent of the 'gap' for First Nations children on the school readiness indicator.

4.1.4.1. OTHER FIRST NATIONS CHILD HEALTH NEEDS, NOT RANKED

The literature indicates that some health issues that are important for First Nations children could not be assessed using a health disparity method because of lack of comparable data for either Canadian or First Nations children as follows:

- In the case of First Nations language, a disparity or 'gap' could not be measured because it is either not relevant for non-First Nations children; or reliable data was not found. However, with 84.1% of First Nations children not speaking or understanding a First Nations language, this is the largest absolute need in terms of the absolute number of First Nations children affected.
- Comparable data on child nutrition are not available. [46] Based on the FNRLHS data, an estimated 25,176 young First Nations children do not regularly eat balanced nutritious meals.
- Canadian rates for *ear infections* are not available. Based on the FNRLHS data, an estimated 6,085 young First Nations children experience ear infections.
- Data on the number of First Nations children living with FASD is limited due to lack of diagnosis for both Canada and First Nations populations. [47] However, the FNRLHS reported a rate of 1.8% of First Nations children are living with FASD.
- There is a lack of First Nations data on rates of alcohol consumption and especially on rates of 'binge' drinking during pregnancy (defined as consuming 5 or more drinks at one time) which has been correlated with FASD. The Canadian data shows a rate of 15.6% for alcohol consumption during pregnancy.
- The Canadian rate for poor motor and social development was 13.6%. There are no data on First Nations children for this indicator.

The data on other child health needs that could not be ranked are presented in Table 10. Inability to speak/understand a First Nations language and the lack of a healthy, nutritious diet both affect more than 25,000 children in the 0-5 age group. These two indicators far outrank the other two indicators (ear infections and FASD). Again, it must be noted that Table 10 does not state which health need is more important or more urgent, it simply presents health needs that can not be ranked by disparity levels (gap).

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[45] 'Social promotion' is the approach of advancing students falling below grade levels to the next grade (and provision of remedial help) based on research showing harmful effects of repeating grades for subsequent learning and an association with increased 'drop-out' rates in later school years. (See Mahoney (2009), Kelly (1999))

[46] The 2004 Canada Community Health Survey provides data on the percentages of Canadian children aged 4 to 9 that are not consuming the recommended daily servings of the four basic food groups according to the Canada Food Guide. These data are not available for First Nations children.

[47] Health Canada estimates that there are 9 per 1000 live births with FASD each year and one child per day is born with FASD, but it does not estimate a prevalence or incidence rate. (See: AADAC (2004)

Table 10: Other First Nations Child Health Needs

Types of Health Needs	% Canada	% FN	% Gap	# FN Children
Not speaking/ understanding First Nations language (3 to 5 year old children)	Not Applicable	84.1%	Not Available	27,858
Children not eating balanced, nutritious meals most of the time	Not Available	38.0%	Not Available	25,176
Children suffering from ear infections	Not Available	9.2%	Not Available	6,085
Children suffering from FASD	Not Available	1.8%	Not Available	1,193
Alcohol used by mothers during pregnancy	15.6%	Not Available	Not Available	Not Available
Poor motor & social development	13.6%	Not Available	Not Available	Not Available

Sources: Evaluation of the CY Cluster Background Literature & Document Review, Auguste Solutions & Associates Inc. for FNIHB, June 2009, Tables 3 and 4. See Appendix 10 Technical Note on Methods for Estimating Child Health Needs. (Data for First Nations children from First Nations Regional Longitudinal Health Survey (RHS) 2002/03. Results for Adults, Youth and Children Living in First Nations Communities. 2005.

Note: In some regions, programs are offered to children from 0-6 years of age. Therefore, the numbers for children aged 0 to 5 under-estimates the total target population.

4.1.5. Step 3: Validation of the Health Needs

The final step in the analysis was to compare the information compiled from the evaluation surveys of Community Staff (118 respondents) and FNIHB Staff (23 respondents). [48] Survey data provided assessments of perceived child health needs for children groupings. [49]

The data reflects two perspectives on priority health needs, namely: (i) at the national and regional CY program level (FNIHB staff); and (ii) at the community level (Community staff).

The top 5 ranked types of health needs [50] for mothers and children by age groups are shown in Table 11.[51] The percentages used to rank the expressed health needs were calculated by identifying the number of times a specific response was identified by the respondents to the questionnaires, and then divided by the number of respondents each of the two groups.

[48] In the surveys, respondents were asked to identify key health priorities/needs in the following categories: mothers (before, during and after pregnancy), children by age group (0-1, 1-2, 3-5), and special needs. Respondents were asked in open-ended questions to identify the 'priority needs' and could provide multiple responses. The percentages in Table 13 reflect the frequency (number of times) that each specific need was identified by respondents.

[49] Neither FNIHB nor the First Nations possessed longitudinal data on health needs, and a comprehensive national health needs assessment has not been conducted. The survey questionnaires therefore asked the respondents for their perceptions on health needs.

[50] The heath needs presented in the table were identified by the respondents when they answered open-ended questions. They were not provided with a list of pre-determined health needs that they were required to choose from.

[51] Qualitative data was analyzed by identifying 'themes' or key categories and tabulating the incidence of responses under these themes.

Table 11: Ranking of Health Needs by Grouping

FNIHB Staff Responses (n=23)			Community Staff Responses (n=118)		
Rank	**Expressed Health Need**	**%**	**Rank**	**Expressed Health Need**	**%**
Mothers During and After Pregnancy					
1	Alcohol/drug use	69.5%	1	Access health information medical services	58.5%
2	Nutrition for mothers	56.5%	2	Addictions, drugs, alcohol and smoking	50.8%
3	Parenting skills, social supports	34.8%	3	Mental and social well being	42.2%
4	Breastfeeding information/support	30.4%	4	Prenatal care (medical)	41.5%
5	Self care, health of mom & baby	30.4%	5	Access, financial support, nutritious food	34.7%
Other Needs	Smoking during pregnancy, Baby care, Practical assistance, Birth & birth control, Personal safety		Other Needs	Support for breastfeeding, Organize, plan and ensure doctor appointments kept, Parenting information and support, Food preparation information and training, Housing, financial security and employment, Transportation to attend programs and obtain medical services, Prenatal vitamins and folic acid	
Infants/Babies (0 to 1 years)					
1	Breastfeeding	69.6%	1	Pre post natal baby nutrition and baby care (excluding breastfeeding)	72.0%
2	Bonding/attachment, parenting	65.2%	2	Social development	18.6%
3	Safety, injury prevention (home/ car)	56.5%	3	Childhood development and stimulation	18.6%
4	Appropriate growth & development	34.8%	4	Immunization	16.9%
5	SIDS	17.4%	5	Education, social and holistic support	12.7%
Other Needs	FASD intervention/diagnosis, High birth weights, Immunizations, Smoke-free environment, Stimulation, Dental health, Smoking during pregnancy, safety		Other Needs	Breastfeeding, Financial support, Culture and language, Transportation	
Toddlers (Children 1 to 2 years)					
1	Parenting, safety , positive interaction	52.2%	1	Holistic support and parental training	35.6%
2	Healthy nutrition	43.5%	2	Screening, home visits, regular checkups	33.9%
3	Appropriate growth & development	26.2%	3	Nutrition and access to nutritious food	30.5%
4	Immunization	17.4%	4	Child development	23.7%
5	First Nations culture & language	13.0%	5	Hygiene and dental and oral health	16.9%
Other Needs	Socialization with other children, Iron deficiency, Anaemia (IDA), Dental health, Smoking during pregnancy, Personal safety, Smoke-free environment, Quality health care access, Screening tools		Other Needs	Immunization, Play and physical activity, Childcare, Culture and First Nations language	

FNIHB Staff Responses (n=23)			Community Staff Responses (n=118)		
Rank	**Expressed Health Need**	**%**	**Rank**	**Expressed Health Need**	**%**
Early Childhood Development (Children (3 to 5 years)					
1	Parenting skills, safety	43.5%	1	Social and cognitive development	42.4%
2	All early childhood development	43.5%	2	Nutrition and access to nutritious food	22.0%
3	Healthy nutrition	39.1%	3	Dental health and hygiene	15.3%
4	Pre-school/school readiness	26.1%	4	School readiness	12.7%
5	First Nations culture & language	17.4%	5	Screening and medical examinations	11.9%
Other Needs	Physical activity daily, Personal safety, injury prevention, Oral/dental health, Speech & language delays, Screening tools, Early intervention services, Smoke & substance free environment		Other Needs	Immunization, Child safety, Transportation, Culture and First Nations language	
Children Living With Special Needs					
1	Specific items for child e.g. equipment	26.0%	1	Access to services	47.5%
2	Direct support for children & families	26.0%	2	Support and financial aid to caregivers	32.2%
3	No services/access to services	17.4%	3	Advocacy	3.4%
4	More services as for other children	13.0%	4	Training staff	3.4%
5	Screening/ early intervention	13.0%	5	Speech and language training	2.5%
Other Needs	Lack of resources, skilled staff, Support inclusion in other programs, Education for care givers, Aid for accessibility, Follow through with referrals		Other Needs		

Source: Surveys of FNIHB Staff & Community Staff, CY Cluster Evaluation, 2009

This survey data is especially useful in identifying the variations in children's health needs at different ages and phases of development between the ages of 0 to 5. Whereas the literature considers 'young children from 0 to 5' as a single group, these data emphasize the variations in health needs among infants, toddlers, and pre-schoolers aged 3-5. In analyzing Table 11 it was found that:

- **Overall, many of the child health needs identified from the literature were also identified in the survey data:** breastfeeding, nutrition, alcohol use during pregnancy, school readiness, injury prevention, early childhood development and childhood illnesses were identified by both FNIHB and community staff.

  Ranking of the health needs differs in the survey data as compared with the rankings based on the literature and data review, for example: alcohol use during pregnancy was the highest ranked need according to FNIHB staff and breastfeeding awareness and support was ranked fourth. Healthy nutrition was consistently ranked highest by community staff for mothers and children of all ages. Healthy growth and development, early childhood development and school readiness were the second and third priorities for children from age 1 to 5 according to both FNIHB and community staff. Other specific issues (such as respiratory diseases, asthma, ear infections) were mentioned in comments by some community staff, although these tended to be grouped within the general category of 'childhood illnesses'.

- **Priority health needs vary considerably by the age of the child**: breastfeeding and infant nutrition were identified by both FNIHB and community staff as the top ranked priority for children aged 0 to 1 year of age. Nutrition and healthy growth and development were ranked highly for children aged 1 to 2 years of age, and nutrition and all aspects of early childhood development were ranked highly for children aged 3 to 5 years of age. Childhood illnesses and injuries were ranked second for children 0 to 1. The importance of pre-school programs and 'school readiness' was one of the top five priorities for children aged 3 to 5 according to both groups of respondents.
- **Ranking of priority health needs at the community level show differences from rankings by FNIHB staff**: community staff gave the highest ranking to nutrition for mothers and all children aged 0 to 5, whereas FNIHB staff gave higher rankings to alcohol use during pregnancy (for mothers), and parenting skills (for children aged 1 to 5. FNIHB staff gave priority to First Nations language and culture (for children aged 1 to 5) whereas these were not among the top five priorities of community staff.
- **Other health needs were identified that do not emerge as clearly from the literature**: immunizations (for children aged 1 to 2) ranked among the top five health needs for children aged 1 to 2 according to both groups of respondents.[52] FNIHB staff ranked 'parenting skills' as the top priority for children aged 1 to 5, and also identified SIDS among the top five priorities for infants. Dental/oral care emerged as among the top five priorities according to community staff. Comments from both FNIHB and community staff identified emerging issues with iron deficiency for mothers and high rate of Iron Deficiency Anaemia (IDA)[53] among young children, and suggested the need for more screening and provision of iron supplements.
- **Children living with special needs were identified as having additional needs by both FNIHB and community staff:** community staff identified the top priorities as education/awareness on how to identify these needs, more access to services in the communities, and direct support for families with children living with special needs. FNIHB staff identified similar priorities as well as assistance for specific health and developmental items that children living with special needs require. Many respondents also mentioned the needs for more specialists, diagnostic and screening services, and transportation. FNIHB staff noted that children living with special needs require more intensive regular services (that is, the services provided to all children), and community staff noted that inclusion of children living with special needs in CY programs creates specialized care and resourcing challenges.
- These needs assessments (based on the opinions of staff working with these children's programs) have both similarities and differences as compared with the child health needs documented in the literature. While there is some consensus that breastfeeding, maternal nutrition, and alcohol (and drug) use during pregnancy are important concerns affecting infant health, there are also a wide range of other factors related to the healthy growth and development of young children that are important. For community-based programming, local perceptions of the priority health needs are an important element in programs to respond to the health needs.

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[52] 'Immunization' was not examined in the literature review since it falls outside the scope of the CY Cluster and it is addressed through a separate program.

[53] There are limited (small scale) studies on the rates of IDA among First Nations children and no estimates of the incidence or prevalence. According to the available information, there are treatment therapies to address the deficiency once it is diagnosed.

4.1.6. Findings on Current Health Needs (R1.1)

Findings 1
Evaluation Sub-question R1.1

The detailed findings on current First Nations health needs are:

- Young First Nations children experience a wide range of health and development needs, and have significant health disparities when compared with other Canadian children.
- Existing literature and data have documented some health needs (such as breastfeeding and smoking) but others could not be measured because of lack of research and data. It is clear nonetheless that the health needs are multi-faceted and not readily prioritized.
- Perceived health needs vary considerably as the child grows older. A health need ranked highly for infants may not be a health need for three year old, e.g., breastfeeding. The same applies for school readiness and many other health needs.
- Some health needs were identified during the surveys and community visits that do not emerge clearly from the literature and document review. These include: immunizations; parenting skills; sudden infant death syndrome; dental/oral care; and increasing concerns with iron deficiencies in young children. The unmet needs of children living with special needs were also identified as a key concern by staff.
- For community-based programming, comprehensive health needs assessments are required to identify and measure priority health needs. Furthermore, a more detailed analysis of child health needs at different stages of development is required. Such health needs assessments could assist in defining the child health priorities within the CY Cluster of programs.
- There are substantial differences in perceptions of health needs and priorities from a community versus FNIHB staff perspective.

4.2. Health Needs Changing Over Time (R1.2)

Table 12: Evaluation Sub-question R1.2

Evaluation Questions	Evaluation Sub-questions
R1. Does the CY Cluster address clearly identified health needs of FN children and youth?	**R1.2** How have these health needs changed over time?

4.2.1. Identifying Changing Health Needs

The literature and document review concluded that there is insufficient consistent time-series or longitudinal data to assess how First Nations child health needs have changed over time. However, positive trends on some indicators have been noted. For example:

- Infant mortality rates have been declining. The First Nations infant mortality rate (the number of babies who die before 1 year of life for every 1,000 babies born) fell from 23.7 in 1980 to 6.4 in 2000. In the same time period, the Canadian infant mortality rate dropped from 10.4/1,000 live births in 1980 to 5.5/1,000 live births in 2000. [54]

- Incidence of low birth weight rates for First Nations children have been declining, and the rates for First Nations and other Canadian children were the same at 5.6% in 2002/03. Low birth weight is defined as babies born weighing less than 2.5 kg. [55]

- Breastfeeding rates have been increasing among First Nations' mothers, as they have among the general population, although rates for First Nations children are still below the national average. The percentages of First Nations children ever breastfed increased from 50% in 1997 to 60% in 2002/03. [56] The national average increased from 79.9% in 1998/99 to 84.2% in 2002/03. [57]

Significant changes in health outcome indicators can be expected to occur over the medium and longer term according to the 2006 Report on the Well-Being of Canada's Children. It states that: 'change over time will occur gradually' and 'a four year period may not allow sufficient time for changes in the lives and well-being of families and children to become apparent'.

The rates of change in First Nations child health indicators are also affected by demographic and other health determinants. First, the volume of First Nations child health needs have been increasing faster than for other children because of higher rates of population growth. According to INAC data, the numbers of First Nations children aged 0 to 4 increased at an average rate of 3% per annum from 2005 to 2008. [58]

At the same time, as Smylie (2009) and others have noted, [59] improvements in the underlying social determinants of health (i.e. incomes, housing, education and others) as a group, have been modest, with considerable variances between regions and communities. Therefore, improvements in health outcomes related to these factors have also been modest.

Studies have shown that historical factors (such as the effects of residential schools) [60] are additional factors associated with negative health outcomes for First Nations children. Therefore, demographic, social and historical factors affect trends in First Nations child health outcomes.

Changes in child health needs were also investigated in the evaluation surveys. Table 13 summarizes data on trends in the types of child health needs. The Community Staff Survey represents the perceptions of trends at the community level, whereas the FNIHB Staff Survey reflects perceived trends at the overall CY Cluster level.

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[54] Health Canada, The Health of First Nations Children Fact Sheet.

[55] The Well-Being of Canada's Children, Government of Canada Report, 2007, page 45 and page 50.

[56] The Well-Being of Canada's Children, Government of Canada Report, 2006, p, 50.

[57] The Well-Being of Canada's Children, Government of Canada Report, 2006, p.45.

[58] See Background Literature and Document Review, prepared for FNIHB by ASA & Associates Inc., 2009.

[59] See Background Literature and Document Review, prepared for FNIHB by ASA & Assoiates Inc., 2009

[60] The literature identifies the effects of residential schools on the health and well-being of First Nations people in general and of children. See: Smylie (2009) and First Nation Regional Longitudinal Health Survey Report (2005).

Table 13: Trends in First Nations Child Health Needs in the Past 5 Years

Changes in Child Health Needs	Community Staff % (n=118)	FNIHB Staff % (n=23)
Increases in all types of health needs	29.6%	9.5%
Increases in some types of health needs	60.5%	33.3%
Decreases in some health needs	0.2%	4.8%
No change in types of health needs but volume of health needs growing	8.7%	52.4%
Totals *	100.0%	100.0
Don't Know	21	5

Sources: Surveys of Community Staff and FNIHB National & Regional Staff.

* Totals exclude "Don't Know' responses.

At the community level, nearly 30% of staff said there were increases in all types of health needs, and over 30% said there were increases in some types of health needs. At the overall CY Cluster level, a third of FNIHB staff said there were changes in some types of health needs, and more than half said there were increasing volumes of health needs (with no change in the types of health needs). It is worth noting that, while aggregate demographic data show that the First Nations population is increasing, trends in individual First Nations vary related to other factors (such as out-migration for work or education, or shortages of housing, and, in some instances, movement back to First Nations) that especially affect younger adults and families with children. Disaggregated analysis would be required to determine rates of growth in needs among communities, and this was beyond the scope of this evaluation. The key finding from these data is that the trends involve more than an increase in volume of 'need' related to population growth and changes in family circumstances.

Follow-up questions identified key changes in the types of health needs as follows:

- **FNIHB staff** reported growing demands for supports related to FASD associated with increased identification and diagnosis of children affected by FASD, and increases in children living with special needs which they felt were not well addressed in regular CY program activities in many communities. Some noted the need for improved screening tools and early intervention. Other FNIHB respondents identified additional or emerging health needs. As noted in the previous section of this report, many FNIHB staff identified health needs related to Sudden Infant Death Syndrome (SIDS), and some identified Iron Deficiency Anaemia (IDA) and access to methadone treatment as specific additional health needs.
- **Community staff** most often reported increasing health needs related to drug and alcohol issues, increasing numbers of teenage mothers, and more diagnosis (and need for support) such as those related to autism, Down's Syndrome, and others. As well, several noted increased awareness among parents of their health needs, and more willingness to participate in programs with growing demand through 'word of mouth'. Some noted that more people are coming back to the First Nation, and others said that 'parents' are causing new parents to bring in their children.

  While these data are qualitative, they do suggest a need for further investigation to assess the extent of changes in types of health needs as related to the CY Cluster activities. As well, a variety of factors seem to be affecting the demand for services at the community level, and more detailed study would be required to assess how prevalent the trends are among different First Nations.

4.2.2. Findings on How Health Needs Changed Over Time (R1.2)

Findings 2
Evaluation Sub-question R1.2

The detailed findings on how health needs have changed over time are:

- There has been some improvement on some health indicators, especially rates of breastfeeding, and declining infant mortality rates.
- At the aggregate level, a key trend is the growing volume of health needs related especially to the higher rate of population growth for First Nations as compared with the Canadian population, and with the movement back to First Nations in some cases. However, rates of growth vary among First Nations.
- Qualitative information from the evaluation surveys suggests that some types of health needs are increasing more rapidly, and newly emerging health needs were also identified. Increased awareness and diagnosis of health issues may also be contributing to increased demand for specific support services in some communities.
- Additional information would be required to determine the extent of the changes in the types of health needs, and to assess the relationship of these health needs to the CY Cluster activities.

4.3. Links Between Health needs and CY Cluster (R1.3)

Table 14: Evaluation Sub-question R1.3

Evaluation Questions	Evaluation Sub-questions
R1. Does the CY Cluster address clearly identified health needs of FN children and youth?	**R1.3** Is there a clear link between the current health needs and the programs delivered by CY Cluster?

4.3.1. Identifying Links between Health Needs and CY Cluster

The current CY evaluation is the first study that specifically examines the link between First Nations child health needs (identified from the literature review) and the programs delivered by the CY Cluster (as outlined in FNIHB program descriptions). Comparison of these two sources of information indicates that there is a logical link between specific CY Cluster program activities and health needs related to pre-natal care, maternal health and nutrition standards (including breastfeeding) and healthy infant development. Also, measures to increase awareness of FASD and reduce use of alcohol during pregnancy are clearly linked to the problems of FASD. The link between current health needs and the CY Cluster were then assessed based on the responses in the FNIHB staff Survey and on data from the evaluation surveys.

FNIHB national program managers were asked to identify the link of the CY Cluster programs to the types of health needs identified earlier from the literature. They were asked to classify program activities into two categories, namely ‘major’ and ‘minor’ activities, as presented in Table 15, on the following page.

It is noted that a number of other FNIHB programs outside the CY Cluster as well as programs delivered by other departments are related to some child health and development issues. Programs outside the CY Cluster were not included in the scope of the CY Cluster evaluation.

Reading across the table, Table 15 shows which elements of the CY Cluster relate to specific health needs. It indicates that some health needs such as nutrition, smoking, alcohol use, birth weights, and child injury are addressed through activities of two or more programs. In other cases such as the early childhood development indicators, the health needs are primarily addressed through one program. Based on this information, there are some health needs (such as hyperactivity, bronchitis, asthma, and ear infections) that were not identified as a major or minor focus of CY activities.

Considering the information on a program by program basis, the main focus of the four CY programs was identified as follows:

- The CPNP clearly has a major focus on child nutrition (including food supplements) [61] , breastfeeding, and high birth weight, as well as some activities related to the issues of smoking and alcohol use during pregnancy (and while breastfeeding). Based on the Survey of FNIHB staff, food security was identified as a primary focus of CPNP's food supplement activities for individuals and families lacking the means of accessing sufficient food on a regular basis. [62]

Table 15: Cluster Activities by Type of Health Needs

Health Needs	CPNP		AHSOR		MCH		FASD	
	Major	Minor	Major	Minor	Major	Minor	Major	Minor
Healthy nutrition	X		X					
Breastfeeding	X							
Smoking during pregnancy		X				X		X
Alcohol use during pregnancy		X				X	X	
High birth weight	X				X			
Child injury				X		X		
Speak/understand FN language			X					
Verbal/language skills development			X					
Repeating grades in school [63]			X					
Child motor & social development			X					X
Hyperactivity								
Bronchitis								
Asthma								
Children's emotional development			X					X
Fetal Alcohol Spectrum Disorder							X	
Ear infections								
Oral (dental) health				X				

Source: Compiled by FNIHB Program Staff, National Office, June 2009

Note: (1) Health Needs defined as health disparities for First Nations children 0-5.

(2) It is recognized that the programs and services available vary from community to community. The above table is an overall summary and does not necessarily represent the services available in any one First Nation.

[61] In some cases, food supplements (such as food baskets) are sometimes described as related to food security. 'Food security' is a broader concept than healthy nutrition. According to Power (2008:95), "the Canadian Government has endorsed the definition of food security that was developed at the World Food Summit in 1996: Food security exists when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life." For Aboriginal people, Power argues for additional consideration of cultural food security given the centrality of traditional good practices to cultural health.

[62] It should be noted that income support programs (e.g. social assistance) are intended to address basic requirements for food, shelter, and clothing. The extent to which CPNP is addressing shortfalls in these programs requires further investigation.

[63] Repeating grades in school (children aged 6-11): CY programs do not work directly with this age group. However, as a whole, all programs should contribute to improved school readiness and performance.

In addition, in some communities, CPNP funding is also used to provide vitamin supplements, although purchase of vitamins may be funded under the NIHB program for women who have prescriptions from health care providers. [64] However, information about the importance of taking pre-natal vitamins is generally provided through CPNP.

- The AHSOR program focuses specifically on child nutrition, use of First Nations languages, child development factors, and helping to prepare children for school. With respect to the issue of 'repeating grades in school' it was noted that, while the CY programs do not work directly with school age children, all programs contribute to improved school readiness [65] and performance.

  Previous reports have noted the reduced incidence of children repeating grades associated with participants in AHSOR. [66]

- The FASD program is primarily focused on alcohol use during pregnancy, but also includes activities related to smoking and child development factors.

- The MCH program has a major focus on maternal and related child health issues such as birth weight, smoking and alcohol use during pregnancy as well as child safety and injury (such as programs for car seat safety).

Overall, this information suggests a close link between key health needs and the four CY programs. This information was confirmed by data from the Survey of FNIHB staff:

- 86% of FNIHB staff said there is a clear link between current child health needs and the CY Cluster. (The remaining 14% of respondents gave a neutral response.)

- A few qualified their answers noting that all CY programs are not available in all communities, and that their responses referred to the general child population and not to children living with special needs. These two points are discussed further in the following two sections.

Based on a rating scale (0-100), these data show a 76% rating for the 'link' between health needs and the CY Cluster at an *overall program level*. The link between health needs and programs at *a community level* is discussed in the following sections.

These indicators suggest that there is a clear link between the perceived health needs and the CY Cluster. It was beyond the scope of this evaluation to assess the 'quality' of this linkage, or the extent to which some needs may be addressed by other (non-CY) programs.

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[64] In communities without health care professionals, obtaining prescriptions can be more challenging, and in these cases vitamin supplements may be provided directly to pregnant women. There is insufficient data to determine the extent to which vitamins are provided through NIHB or CPNP.

[65] Statistics Canada's National Longitudinal Survey of Children & Youth (NLSCY) defines 'readiness to learn at school' as including 'receptive (or understood) vocabulary, communication ability, number knowledge, copying and using symbols, self control of behaviour, attention, work effort, curiosity, cooperative play, independence in dressing, and independence in cleanliness." In the NLSCY, vocabulary, number knowledge, and copying and symbol use were assessed using direct measures. Other variables were measured by asking parents how their children behave. (See Statistics Canada (2009))

[66] See Report on the FNRLHS, 2005.

4.3.2. Findings Links between Needs and CY Cluster (R1.3)

Findings 3
Evaluation Sub-question R1.3

The detailed findings on the links between health needs and the CY Cluster are:

- Overall there is a clear link *at a cluster level* between many of the key child health needs and CY program activities.
- However, the four CY Cluster programs are provided in a minority of First Nations. CY programs and services available vary from community to community. Therefore, many First Nations have an incomplete range of programs and services to address child health issues.
- Furthermore, some of the key child health needs identified are not a major or minor focus of the CY Cluster. Smoking, child injury and dental health are only a minor focus of some CY Cluster programs, and other childhood health issues (hyperactivity, bronchitis, asthma, and ear infections) that are not addressed by the CY Cluster may be addressed through other programs.
- FNIHB has some other initiatives related to some of these issues such as child injury, and there are non-FNIHB programs related to child care and early childhood development that cut across many of the same issues.

Further research across a broader range of programs would be required to assess the *quality* of the link between the CY Cluster and child health needs, the extent to which non-CY Cluster programs and activities address child health and development needs, and to determine the extent of 'gaps' in CY and other (non-CY) programs to address the health needs.

4.4. Meeting Maternal & Child Health Needs (R1.4)

Table 16: Evaluation Sub-question R1.4

Evaluation Questions		Evaluation Sub-questions	
R1.	Does the CY Cluster address clearly identified health needs of FN children and youth?	**R1.4**	Are the health needs, in the area of maternal and child health, being met?

This evaluation sub-question is specific to the types of health needs addressed through the CY programs and services. It was recognized that there are a wide range of other health needs (including primary health care) that go beyond the scope of the CY cluster programs and this evaluation, and no data were compiled on the wider range of health needs.

Given the lack of information available in the literature and documents reviewed to address this evaluation sub-question, data from the evaluation surveys of program participants, community staff and FNIHB staff were used. The surveys were carefully designed to ensure that the questions were specific to the types of maternal and child health needs relevant to the CY cluster programs. In these surveys, respondents were asked to provide their ratings of how well the CY cluster programs were meeting the needs of the mothers and children served through the CY programs.

All respondents in these surveys were directly involved in the CY cluster programs, and the scope of the survey questions throughout were made clearly explicit as being related to the CY programs only. Therefore, the survey data are specific to the CY programs and the types of health needs addressed for mothers and children, and do not include other types of health needs.

Table 17 summarizes the ratings of the CY Cluster programs from *three different perspectives*. FNIHB national and regional staff rated the CY Cluster at an overall program level across all communities whereas community staff rated how well the CY programs were meeting needs in their own communities which vary according to the range of programs and services available in each community. CY program participants rated their satisfaction with how well the programs they receive meet their and their children's health needs.

Table 17: CY Cluster Meeting Needs

Responses	Program Participants % (n=225)	Community Staff % (n= 118)	FNIHB Staff % (n=23)
Very well / Well (Very/somewhat satisfied)	89.7%	59.5%	20.0%
Fairly well (Neither)	8.0%	36.9%	65.0%
Poorly / Not at all (Somewhat//Very dissatisfied)	2.3%	3.6%	15.0%
Total (excluding don't knows)	100.0%	100.0%	100.0%

Source: Surveys of Community and FNIHB Staff and CY Program Participants

Notes: In the FNIHB Staff Survey, 'meeting the health needs' was defined as providing the types and amounts of services that children and parents require. In the Community Staff Survey, the question was specific to the services provided in the CY programs in their communities.

In the Program Participants Survey, the question was specific to how well the children's programs meet their and their children's health and wellness needs. The question was worded as a 'satisfaction' rating, and the 5-point scale was summarized in Table 17 for the top two, mid-point and lower two categories i.e. 'Very satisfied/satisfied', 'Neither satisfied nor dissatisfied', and 'Somewhat/Very Dissatisfied'.

These data show that:

- At the overall CY Cluster level (nationally and regionally), 20% of FNIHB staff rated the programs as meeting health needs very well or well, 65% said fairly well, and 15% said poorly or not at all. In comments it was noted that responses referred to 'regular' programs, and that the programs did not address special needs.
- At the community level, nearly 60% of community staff delivering these programs rated them as meeting health needs very well or well, and 36.9% said fairly well.
- At the level of program participants, ratings of how well the programs meet their health needs were higher than the ratings of both the FNIHB and community staff. Nearly 90% of participants in the programs were very or somewhat satisfied with how the programs meet their and their children's health needs (60.1% very satisfied and 29.6% somewhat satisfied). Only 2.3% were somewhat or very dissatisfied.

These data need to be considered in the context of other information presented later in this report on the effectiveness questions.

To provide a more detailed assessment on how well the CY Cluster addresses specific health needs, the FNIHB and community staff were asked to rate how well the programs address the 15 specific health needs. Table 18 summarizes the percentages of the FNIHB who said that they 'strongly agree' or 'agree' that the CY programs address the 15 specific health service needs listed. Data from community staff assessments are presented in Section 4.5 because it relates to how well health needs are being met at the community level.

Table 18: CY Cluster addressing health service needs (as reported by FNIHB staff)

Health Service Needs:	CY Cluster is addressing needs (n=23)
Breastfeeding promotion and education	96%
Education about risks associated with alcohol use during pregnancy	91%
Breastfeeding support	83%
Maternal (pre & post natal) nutrition screening, education, counselling	82%
Access to prenatal health care services (midwife, nurse, etc.)	80%
Promotion of First Nations culture for child and families	78%
Preparing children for school	76%
Education about risks associated with non-prescription drug use	64%
Information and access to oral/dental health services	60%
Promotion of First Nations language for child and families	55%
Information about the importance of physical activity for children	33%
Access to nutritious food for mother, child & family	32%
Support for maternal mental wellness (e.g., post partum depression)	10%
Supports for children living with special needs	10%
Education about children living with special needs	5%
Average	**57%**

Source: Survey of FNIHB Staff, 2009.

Table 18 demonstrates that:

- The CY Cluster is rated highest for addressing health needs relating to breastfeeding promotion (96%) and breastfeeding support (83%) education about alcohol use during pregnancy (91%), maternal nutrition (pre- and post-natal) (82%), and access to pre-natal care (80%);
- Promotion of First Nations culture was rated higher than language (78% versus 55%). Preparing children for school was rated at 76%;
- Access to nutrition food was rated at 32%;
- Some of the lowest ratings were for education and supports for children living with special needs (5% and 10%); and
- The average rating on these 15 health service needs was 57%.

4.4.1. Findings on Meeting Maternal and Child Health Needs (R1.4)

Findings 4
Evaluation Sub-question R1.4

The detailed findings on how the Cluster meets health needs, as reported by FNIHB staff, are:

- The CY Cluster is moderately successful in addressing the health needs of program participants achieving an overall rating of almost 60%;
- CY programs appear to be more closely matched to some health needs than others; and
- The CY Cluster as a whole appears to be least well matched to healthy nutrition and the needs of children living with special needs.

4.5. Belief Cluster Meets Community Needs (R1.5)

Evaluation Questions		Evaluation Sub-questions	
R1.	Does the CY Cluster address clearly identified health needs of FN children and youth?	**R1.5**	Does the FN community staff, leadership and CY cluster partners/stakeholders believe that the programs delivered by the CY cluster are meeting the maternal and child health needs of their community?

This question addresses how well the health needs of the community as a whole are being met, and not just the needs of those members who are participants within the CY cluster of programs.

This question was addressed based on data from the surveys of community and FNIHB staff. Information from the Community Staff Survey is especially useful to address questions at a community level [67] (refer to Table 19). Data from the Community Staff Survey in 37 communities include a range of responses depending on how many programs are in each community. Results from this survey provide indications of findings that may not be generalized to all First Nations.

Table 19: CY Cluster Meeting Communities' CY Health Needs

Responses	Community Staff % (n=118)	FNIHB Staff % (n=23)
Agreed	74.1%	35%
Neither agreed/disagreed	16.7%	35%
Disagreed	9.2%	30%
Total (excluding Don't Know)	100.0%	100%

Source: Surveys of Community and FNIHB Staff

[67] It should be noted that data from the Community Staff Survey were obtained from 37 site visit communities that include communities with three or four CY Cluster programs, and not communities with lesser numbers of CY programs.

Based on the community staff survey, the CY Cluster is successful in meeting the maternal and child health needs of the communities:

- 74% of community staff said it was meets the maternal and child health service needs in the communities. FNIHB staff ratings were lower at 35%;
- 30% of FNIHB staff and less than 10% of community staff said it did not meet the health needs.

FNIHB staff ratings were much lower than those of the community staff, possibly due to their broader perspective on health needs and service gaps across all First Nations communities.

To better understand the health service needs addressed in the communities, the community staff were asked to rate the Cluster based on the same 5 specific health service needs used in the FNIHB Staff Survey. As shown in Table 20 that follows:

- These ratings at a community level were higher on average (67.2%) than the FNIHB staff ratings of the CY programs (57%). In the communities surveyed, staff rated meeting health service needs higher on: access to nutritious food (71.8%); prenatal care (84.2%); preparing children for school (82.9%); and dental and oral health care (86.6%). They gave below average ratings to First Nations language and culture, and education about drugs, special needs, and physical activity.
- The highest ratings (83.5%) were for prenatal health care, preparing children for school and dental health care. The lowest (35.7%) were for special needs, and promotion of First Nations language (48.5%).

These findings may reflect the range of programs and availability of specific services in the communities surveyed.

Table 20: CY addressing health service needs: Community Staff Ratings

Health Service Needs:	CY Cluster is addressing needs (n=118) [68] % Strongly agree/agree
Maternal (pre & post natal) nutrition screening, education, counselling	83.5%
Access to nutritious food for mother, child & family	71.8%
Access to prenatal health care services (midwife, nurse, etc.)	84.2%
Breastfeeding promotion and education	75.9%
Breastfeeding support	75.0%
Promotion of First Nations language for child and families	48.5%
Promotion of First Nations culture for child and families	61.1%
Preparing children for school	82.9%
Education about risks associated with alcohol use during pregnancy	78.3%
Education about risks associated with non-prescription drug use	64.8%
Support for maternal mental wellness (e.g., post partum depression)	53.7%
Education about children living with special needs	35.7%
Supports for children living with special needs	41.2%
Information and access to oral/dental health services	86.6%
Information about the importance of physical activity for children	64.4%
Average	**67.2%**

Source: Survey of Community Staff in communities, 2009.

[68] % is total of those who responded either Strongly Agree or Agree. Excludes the response 'Do not know.'

4.5.1. Findings on Belief Cluster Meets Community Needs (R1.5)

Findings 5
Evaluation Sub-question R1.5

The detailed findings on the belief on how the Cluster meets community needs are:

- The range of CY programs delivered varies among First Nations because to-date funding was provided by program and not all programs are funded in all First Nations.
- At the community level, the CY Cluster was rated as successful in meeting community health needs by 74% of community staff and 35% of FNIHB staff in the communities surveyed.
- Some health needs were rated as better met by the CY Cluster than others. Community staff rated the programs as most successful in meeting health needs for prenatal care, preparing children for school and dental health. Below average scores were reported on First Nations languages, drug use, physical activity, and special needs which were least well met according to more than a third of community staff.

4.6. Summary of Principal Findings, Health Needs (R1)

Evaluation Questions	
R1.	Does the CY Cluster address clearly identified health needs of FN children and youth?

Using the detailed findings for each of the sub-evaluation questions (R1.1 to R1.5), the principal findings to evaluation question R1 were developed and are presented in the following page.

SUMMARY OF PRINCIPAL FINDINGS FOR EVALUATION QUESTION R1

The principal findings on health needs are:

- Gaps in current health needs of young First Nations children include a wide range of significant disparities or 'gaps' when compared with other Canadian children. The existing literature has documented and measured some health needs (such as breastfeeding and smoking), but other needs have not been measured due to the apparent lack of research and data.

  Health needs vary as the child gets older, and include other concerns not identified in the literature, but identified within the surveys conducted for this evaluation. In-depth needs assessments of health needs are required as a basis for defining child health priorities in the CY Cluster and for community-based programming.
- Trends in health needs over time indicate an improvement on some health indicators, especially in rates of breastfeeding (initiation but not duration), and declining infant mortality rates. At the aggregate level, a key trend is the growing volume of health needs related especially to the higher rate of population growth for First Nations as compared with the Canadian population (higher birth rates and members returning to their communities). However, rates of growth vary among First Nations.

  Some types of health needs are increasing more rapidly, and newly emerging health needs were also identified. Additional information would be required to determine the extent of changes in the types of health needs and assess the relationship of these health needs to the CY Cluster activities.
- Overall there is a clear link at a cluster level between all of the key child health needs and CY program activities. However, four CY Cluster programs are provided in a minority of First Nations, and CY programs and services available vary from community to community. Therefore, many First Nations have an incomplete range of programs and services to address the key child health issues. Also, some of the child health needs identified are not either a major or minor focus of the CY Cluster but may be addressed through other programs.
- FNIHB has some other initiatives related to some of the health needs such as the child injury prevention, and there are non-FNIHB programs related to child care and early childhood development that cut across many of the same issues. Further research across a broader range of programs would be required to assess the extent to which non-CY Cluster programs and activities address child health and development needs, and to determine the extent of 'gaps' in programs to address the health needs.
- The CY Cluster is moderately successful in addressing health needs and is more closely matched to some health needs than other health needs. The CY Cluster at the overall program level appears to be least well-matched to the health needs for healthy nutrition and for children living with special needs. The best-matched health needs are breastfeeding and prenatal care for mothers.

  70% of community staff and 35% of FNIHB staff rated the CY Cluster as successful in meeting health needs, and some health needs were better met by the CY Cluster than others. Community staff rated the programs as most successful in meeting health needs for prenatal care, preparing children for school and dental health. Below average scores were reported on First Nations languages and culture, drug and alcohol use during pregnancies, physical activity. Special needs which were least well met according to about a third of community staff.
- At an overall Cluster level, the CY Cluster was found to address some clearly identified health needs of young First Nations children. However, the CY programs do not address all health needs and are not all available in all communities. At the community level, some types of health needs in the communities are better addressed than others. These findings suggest that there are important health needs that are not being addressed including special needs. Further investigation of the CY and non-CY programs would be required to assess potential service gaps.

Section 5. RELEVANCE TO FEDERAL GOVERNMENT PRIORITIES

This section presents the analysis and findings for the second of the eight evaluation questions.

Table 21: Evaluation Issues and Evaluation Questions

Evaluation Issues	Evaluation Questions
Relevance	**R1.** Does the CY Cluster address clearly identified health needs of FN children and youth?
	R2. To what extent is this cluster linked to a Government priority?
	R3. To what extent is this cluster appropriate to the federal government and a core federal role?
Effectiveness	**E1.** Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?
	E2. Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?
	E3. Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?
	E4a. Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
	E4b. Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

Government priorities are generally identified in formal statements (such as the Speech from the Throne and Budget Statements), in agreements with other parties for special initiatives, and in official announcements of program funding. Announcements of enhanced or new funding related to specific programs and services represent the implementation of priorities and agreements for specific areas of action to address priority issues.

The data required to undertake the analysis and produce the findings to this evaluation question came largely from the literature and document review and the key informant interviews conducted with FNIHB staff.

5.1. Cluster Linked to Budget and/or Priorities (R2.1)

Table 22: Evaluation Sub-question R2.1

Evaluation Questions	Evaluation Sub-questions
R2. To what extent is this cluster linked to a Government priority?	**R2.1** According to what Budget or other priority was this cluster (or programs within the cluster) created and what year?

Programs within the CY Cluster evolved through a series of government decisions and federal budgets since 1998. The CY Cluster was formed in 2005 along with a restructuring of all FNIHB contributions programs.

In 1997, the federal government announced the expansion of the Aboriginal Head Start Program to include First Nations children and families living on-reserve and the launch of the AHSOR Program in October 1998. This program resulted from:

- Commitments in Gathering Strength – Canada's Aboriginal Action Plan, Securing Our Future Together (1999);
- September 1999 Speech from the Throne;
- Response to recommendation in the Report on the Royal Commission on Aboriginal Peoples, 1996; and
- Launch of the Aboriginal Head Start Initiatives in 1995 as an early intervention program for Aboriginal children in urban areas and large northern communities.

The framework for current government priorities for First Nations children is intrinsically linked to broader Canadian policies for children following from the 1999 National Children's Agenda. The 1999 'National Children's Agenda – Developing a Shared Vision' was designed in collaboration with the 5 National Aboriginal organizations [69] and documented the health needs of Aboriginal children based on their higher risks of negative health and education outcomes.

In 2000, the federal government signed the F/P/T [70] Early Childhood Development Agreement 'to improve and expand services and programs they provide for children under six years of age and their families'. [71] The four priority areas for action and for the investment of the additional federal funding (a total of $3.2B from 2001 to 2008) were:

- Promote healthy pregnancy, birth and infancy;
- Improve parenting and family supports;
- Strengthen early childhood development, learned and care; and
- Strengthen community supports

The January 2001 Speech from the Throne committed the Government of Canada to *"work with First Nations to improve and expand the early childhood development programs and services available in their communities. It will also expand significantly the Aboriginal Head Start Program to better prepare more Aboriginal children for school and help those with diverse needs."* [72]

This led to the October 2002 Federal Strategy on Early Childhood Development for First Nations and Other Aboriginal Children which provided additional funding of $320M over five years to enhance programs and services that address the early childhood development needs of Aboriginal children [73] with the following priority areas for this additional funding:

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[69] Assembly of First Nations, Métis National Council, Native Women's Association of Canada, Congress of Aboriginal Peoples and Inuit Tapirisat Kanatami of Canada.

[70] Federal/Provincial/Territorial (F/P/T)

[71] The Well-Being of Canada's Young Children: Government of Canada Report 2006, page 1.

[72] Quoted in AHSOR Program Guidelines, Health Canada, 2009, Appendix A, Page 2.

[73] News Release, Government of Canada February 28, 2005 "Investing in our Future: Government of Canada reports on progress in early childhood development", Page 2.

- New investments to enhance existing programs (Aboriginal Head Start in Urban and Northern Communities, Aboriginal Head Start On-Reserve, and the First Nations and Inuit Child Care Initiative) and to intensify efforts to address Fetal Alcohol Spectrum Disorder in First Nations communities;
- Advancing research and knowledge;
- Building capacity and networks; and
- Working towards better integration of federal childhood development programs and services.

The announcement increased the AHSOR Program annual budget from $25M to $46.5M per year. The priorities identified for these additional funds for the AHSOR program were:

- Improve access to quality early childhood care and learning so that children are ready to learn in formal school settings;
- Enhance the capacity of Aboriginal communities to assess the health needs of young children and their families;
- Support the development of new sites, expansion of existing project capacity and respond to project challenges and gaps; and
- Increase parents' and caregivers' knowledge and skills by increased accessibility to parent supports and education and training opportunities for caregivers.

Therefore, the period from 1997 to 2002 saw significant steps in identifying the government's priorities around early childhood development issues generally and for First Nations, and the translation of these priorities into measures to address the priorities.

The federal government has repeatedly reaffirmed (in Speeches from the Throne, Budgets and policy documents) its priority to improve the health and living conditions of First Nations people, enhance early childhood development, and the long-term vision of integration with provincial health systems. Over the past few years, these commitments have been affirmed in federal Budgets from 1998 to 2008. As well, these Budgets have recognized the importance of broader social factors affecting First Nations health and committed to investments in the determinants of health. Key statements of priorities include:

- Government Decision June 1998 (expansion of Aboriginal Headstart to On-reserve)
- Federal Budget February 1999 (CPNP)
- Speech from the Throne January 2001 & Government Decision July 2002 for Early Childhood Development (5 years of funding for AHSOR & FASD)
- Federal Budget February 2005 (MCH Program funding over 5 years)
- Budget 2006 committed new resources to improve water quality and housing on-reserve, education outcomes and socio-economic conditions of women, families and children.
- Budget 2007 included commitments related to the development of individual property ownership on-reserve and an enhancement to the justice strategy.
- Budget 2008 committed new resources for economic development, education, and new prevention models of child and family services. This Budget also included extended commitments to a First Nations Water and Wastewater Action Plan.

Successive federal budgets have emphasized the federal government's commitment to work with Aboriginal leaders as well as the provinces and territories to develop new approaches with workable solutions and better health outcomes for First Nations. In December 2007, the Minister of Health affirmed the Government of Canada's commitment to putting First Nations children first through support of Motion 296, 'Jordan's Principle', which will address the health needs of on-reserve First Nations children with multiple disabilities requiring services from multiple levels of government.

This Motion was supported unanimously by the House of Commons. The federal government has also recognized the importance of broader social factors concerning the health of Aboriginal peoples through investments in the areas viewed as determinants of health. Collectively, Budget commitments since 2006 relate to broader strategic objectives of improving social and economic conditions over time which relate to the government's strategic outcome of improving health for First Nations people.

Since 2002, the key developments in government priorities for First Nations children have been in improving the ***continuum*** of services particularly for maternal and child health. In September 2004, First Nations and Aboriginal leaders met to discuss joint actions to improve Aboriginal health and adopt measures to address the disparity in the health status of this population. They agreed to work together to develop a blueprint for improving health status and health services. On September 14, 2004 at a special meeting of First Ministers and National Aboriginal leaders, the Prime Minister announced new "upstream" investment to improve the health status of First Nations and other Aboriginal people.

The Government of Canada announced $700M over 5 years in new federal commitments that address *urgent and critical aspects of a longer term plan which included funding for maternal and child health and early childhood development.* The February 2005 Budget confirmed these investments including *$110M over 5 years for the new* Maternal Child Health (MCH) Program in First Nation communities.

MCH began in 2006, adding to the growing continuum of services that support Aboriginal mothers, children and families from before pregnancy to the time a child enters school, thereby complementing other established programs (AHSOR, FASD and CPNP). Development of these additional services was viewed as contributing to "the positive growth and development of infants, children and their mothers so that health outcomes of these groups reach levels that have been obtained by non-Aboriginal Canadians." (Report on Plans & Priorities, 2005-2006, Page 20).

According to the Report on Plans and Priorities 2007-2008, the priorities for 2007-2008 were to continue improvement of the continuum of programs and the coverage of communities, and increasing participation by individuals and families in the programs provided in communities.[74]

Since 2002, successive federal budgets have provided additional funding to address priority areas such as improved water quality and housing, education, social and economic development. Collectively, such initiatives could be expected to improve social and economic conditions and, in line with the social determinants of health model, lead to improved health outcomes for First Nations children, families and communities.

[74] Health Canada through the FNIHB has focused on working with National Aboriginal Organizations to implement the MCH Program and enhancing health promotion programs already in place (CPNP and FASD), and on expansion of the AHSOR through increased training and facilities to deliver services. By 2007-08, MCH had already reached 2,200 mothers and their children according to the CY Cluster Performance Report.

5.1.1. Findings on Cluster Linkage to Budget and Priorities (R2.1)

Findings 6
Evaluation Sub-question R2.1

The detailed findings on the Cluster's linkages to the federal government's budget and/or priorities are:

- The CY Cluster is clearly linked to overall federal priorities to enhance the health and well-being of First Nations children living on reserve. Successive federal government decisions and budget since the later 1990s have expanded policies and funding to enhance child health and well-being, most recently including federal budgets in 2005, 2006, 2007, and 2008.
- Since 2002, the CY Cluster relates to the Federal Strategy on Early Childhood Development for Nations and Other Aboriginal Children.

5.2. Cluster Relative to Government Priorities (R2.2)

Table 23: Evaluation Sub-question R2.2

Evaluation Questions	Evaluation Sub-questions
R2. To what extent is this cluster linked to a Government priority?	**R2.2** **How** does this program relate to current Government priorities and explain how its expected results are aligned to current Government priorities?

Four broad federal strategic directions were identified from policy and budget documents, namely:

- Improving the health and well-being of First Nations people in general;
- Improving early childhood development of First Nations children and youth;
- Transferring delivery and administration of health programs to First Nations control; and
- Increasing Integration of the health care system

There is a clear link between these overall strategic objectives and the CY Cluster logic model, program activity architecture, and the program descriptions for all components of the CY Cluster. The overall objective of the CY Cluster is to improve the mental, physical, emotional and spiritual health and wellbeing of First Nations children and youth, their families and communities.

According to the Program Activity Architecture, the CY Cluster includes 5 broad categories of activities, [75] namely:

- Collaborate with First Nations, F/P/T authorities & organizations
- Deliver maternal & child health priorities, programs & supports
- Lead, innovate & incorporate evidence-based best practices in maternal & child health programs and supports

[75] Appendix B, Community Programs, Terms & Conditions, Health Canada, 2005.

- Educate & create awareness of First Nations maternal & child health priorities, programs & supports
- Build capacity among First Nations individuals, families & communities

The CY Cluster logic model identifies the expected outputs and outcomes related to these five categories of activities. The logic model identifies the immediate, intermediate and final outcomes of the CY Cluster activities [76] as follows:

Immediate outcomes:

- Increased & improved collaboration & networking;
- Improved continuum of programs & supports in First Nations communities;
- Increased participation of First Nations individuals, families and communities in programs & supports; and
- Increased awareness of healthy behaviours.

Intermediate outcomes:

- Increased practice of healthy behaviours;
- Increased First Nations community ownership & capacity to deliver maternal & child health programs & supports;
- Improved access to quality well-coordinated programs & supports to First Nations individuals, families & communities; and
- Improved access to information, professional development & expertise on maternal & child health.

Final outcome:

- Improved health status of First Nations individuals, families & communities.

Review of the detailed program descriptions and activities in the four elements of the CY Cluster [77] indicates that there are key components in the programs that relate to the CY Cluster activities and expected outcomes identified above.

5.2.1. Findings on Cluster Relative to Government Priorities (R2.2)

Comparison of the CY Cluster activities, program components and expected outcomes with the broad government strategic objectives indicates that the CY Cluster is consistent with overall priorities of improving the health of First Nations individuals, families and communities including early childhood development and the link to the National Children's Agenda, transferring delivery of health programs to First Nations, and increasing integration in the health care system.

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[76] Children and Youth Logic Model, Community Programs, Terms and Conditions, Health Canada, 2005.

[77] Based on Health Canada, Community Programs Terms & Conditions, 2005; FNIHB, Program Compendium, March 2007; FNIHB, Aboriginal Head Start On Reserve Program Framework, 2009; FNIHB, Maternal Child Health Program. Program Guidelines, 2008; Health Canada, Performance Report 2004-05 to 2006-07 CY Cluster, FNIHB, 2008.

Findings 7
Evaluation Sub-question R2.2

The detailed findings on Cluster Relative To Government Priorities (R2.2)

- The CY Cluster is related to and consistent with current government priorities of improving health and early childhood development for First Nations children.
- As an integrated group of programs since 2004, the CY Cluster specifically relates to the priority to work towards integration of federal childhood development programs and services, and the 2005 federal government decision for enhancing early learning and child care for First Nations children living on reserve.

5.3. Summary of Principal Findings, Cluster Relative to Government Priorities (R2)

Evaluation Questions	
R2.	To what extent is this cluster linked to a Government priority?

Using the detailed findings for the evaluation sub-questions (R2.1 and R2.2), the principal findings to evaluation question R2 were developed and are presented below.

SUMMARY OF PRINCIPAL FINDINGS FOR EVALUATION QUESTION R2

The principal findings on the linkage of the cluster to government priorities are:

- The CY Cluster is clearly linked to overall federal priorities to enhance the health and well-being of First Nations children living on-reserve, and is consistent with 1988 federal policy to transfer health services to First Nations control.
- Since the late 1990's, successive federal government decisions and Budgets have expanded policies and funding available to achieve two overall objectives: first, to provide services to First Nations children on-reserve that are available to other children living in similar geographic areas, and, secondly, to develop and enhance a continuum of services for child health and well-being from prenatal stages to age 5.
- The CY Cluster (as an integrated group of activities) specifically relates to the 2002 Federal Strategy on Early Childhood Development for First Nations and Other Aboriginal Children and its priority to work towards better integration of federal childhood development programs and services, and a government decision in 2005 for enhancing early learning and child care for First Nations children living on-reserve.
- Since 2003, the overall rational for the CY Cluster has related to the principles of investing 'upstream' to achieve improved health outcomes for First Nations and recognition of the importance of the early years in child development as a foundation for lifelong health and well-being.

Section 6. RELEVANCE TO FEDERAL GOVERNMENT ROLES

This section presents the analysis and findings for the third of the eight evaluation questions.

Table 24: Evaluation Issues and Evaluation Questions

Evaluation Issues	Evaluation Questions	
Relevance	**R1.**	Does the CY Cluster address clearly identified health needs of FN children and youth?
	R2.	To what extent is this cluster linked to a Government priority?
	R3.	To what extent is this cluster appropriate to the federal government and a core federal role?
Effectiveness	**E1.**	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?
	E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?
	E3.	Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?
	E4a.	Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
	E4b.	Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

As stated in the previous section, government priorities are generally identified in formal statements (such as the Speech from the Throne and Budget Statements), in agreements with other parties for special initiatives, and in official announcements of program funding. Announcements of enhanced or new funding related to specific programs and services represent the implementation of priorities and agreements for specific areas of action to address priority issues.

The data required to undertake the analysis and produce the findings to this evaluation question came largely from the literature and document review and the key informant interviews conducted with FNIHB staff.

6.1. Is CY Cluster Consistent with Federal Roles? (R3.1)

Table 25: Evaluation Sub-question R3.1

Evaluation Questions		Evaluation Sub-questions	
R3.	To what extent is this cluster appropriate to the federal government and a core federal role?	**R3.1**	**To** what extent is the CY Cluster programs consistent with federal government roles & responsibilities to address FN health?

The roles and responsibilities of the federal government with respect to First Nations health have been evolving and continue to evolve as the transfer of delivery and administration of health care to First Nations proceeds. The CY Cluster, as an integrated strategy for children's programs, has also been evolving since 2004. The Cluster approach seems to be aligned with trends underway toward a declining federal role in 'program' responsibilities associated with transfer of funding through the Tripartite Agreement mechanism.

The current role of the federal government in health services for First Nations is based on the 1979 federal Indian Health Policy which stems from the federal historical role in the provision of such services. Federal responsibilities flow from constitutional and statutory provisions, treaties and customary practice.

Health Canada notes that:

> "The Federal Indian Health Policy is based on the special relationship of the Indian people to the Federal Government, a relationship which both the Indian people and the Government are committed to preserving. It recognizes the circumstances under which many Indian communities exist which have placed Indian people at a grave disadvantage compared with other Canadians in terms of health, as in other areas." *(Health Canada, Indian Health Policy 1979, HC website, Oct 25, 2007)*

The goal of the Indian Health Policy as stated by Health Canada (Ref www op cit) is "to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves". This Policy has three 'pillars', namely, community development, the traditional relationship of the Indian people to the Federal Government, and the interrelated Canadian health system which are described as follows in the summary from the Health Canada website.

Community development includes both 'socio-economic development and cultural and spiritual development to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental and social well-being.'

The traditional relationship of the Indian people to the Federal Government 'promotes the capacity of Indian communities to achieve their aspirations' and, 'this relationship must be strengthened by opening up communication and by encouraging their greater involvement in the planning, budgeting and delivery of health programs.' In the interrelated health system, the federal government 'is committed to promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health.'

A key element of this policy for current federal health programs for First Nations peoples is the interrelated health system that involves responsibilities of federal, provincial or municipal governments and Indian bands. While the respective roles and responsibilities continue to evolve, the policy recognizes that:

- The most significant federal roles are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment;
- The most significant provincial and private roles are in the diagnosis and treatment of acute and chronic diseases and the rehabilitation of the sick; and
- First Nations communities have a significant role in health promotion and in the adaptation of health service delivery to the specific needs of their communities.

Since 1986, the federal government has implemented a long-term plan to transfer delivery and administration of health care programs to First Nations control.

The federal role in delivery of health services to First Nations includes provision of some health services on the basis of policy and historical practice as well as support to the provincial and territorial governments to provide health services to all Canadians including First Nations people through funding for hospital and physician services and other critical aspects of the health system. In 2004, First Ministers agreed on a ten year plan to strengthen health care for all Canadians including First Nations peoples.

The federal historical role in the provision of health services to First Nations and the jurisdiction of Parliament generally over First Nations and their lands relates to section 91(24) of the Constitution Act, 1987. Although the Indian Act provides for certain regulations making powers relating to the health of First Nations people, no such regulations presently exist. The current policy framework is also the result of the treaties, modern land claim agreements, self government agreements, and the federal-provincial or federal-territorial agreements that have further defined the respective roles of the various parties.

Within this overall and evolving federal policy framework, the responsibility for First Nations health programs and services rests with Health Canada.

6.1.1. Findings on How the Cluster is Consistent with Federal Roles

Findings 8
Evaluation Sub-question R3.1

The detailed findings on how the Cluster is consistent with the Federal Government's roles are:

- The CY Cluster is consistent with federal government roles & responsibilities to address First Nations' health. The individual program components and the Cluster as a whole are consistent with the goal of the Indian Health Policy and the federal roles in public health and health promotion.
- The federal government is continuing to implement the long-term plan to transfer delivery and administration of health care programs to First Nations control.

6.2. Nature of the Federal Role To Deliver CY Cluster (R3.2)

Table 26: Evaluation Sub-question R3.2

Evaluation Questions		Evaluation Sub-questions	
R3.	To what extent is this cluster appropriate to the federal government and a core federal role?	**R3.2**	**Explain** the nature of the federal government's role and mandate to deliver this program.

Health Canada provides health services to First Nations as a matter of policy using the Annual Appropriations Act to obtain Parliamentary approval. The Minister responsible for Health Canada is accountable to the Canadian Parliament for the federal Indian Health Policy and the health programs and services provided to First Nations peoples.

Departmentally, Health Canada is responsible for health programming for First Nations through its First Nations and Inuit Health Branch (FNIHB) and Regions and Programs Branch (RAPB). Through these branches, Health Canada supports the delivery of primary health care, community-based health promotion (Community Health Programs), and health protection services for First Nations. The CY Cluster falls within the community-based health promotion programs. The community health programs provide a range of health services and programs to First Nations people who live on reserve that are similar to programs provided by provinces to their residents, as well as targeted programming for at-risk populations similar to those programs provided to all Canadians through the Public Health Agency of Canada (such as the Canada Prenatal Nutrition Program and Aboriginal Head Start).

According to the CY Cluster RMAF (Health Canada, Dec. 2006), FNIHB's mandate is:

- To ensure availability of and access to health programs and services;
- Assist First Nations to address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and,
- Build strong partnerships with First Nations to improve the health system.

Furthermore, the RMAF states that the strategic role of FNIHB is to improve health outcomes and reduce health inequalities between First Nations and other Canadians, and the objectives of FNIHB activities are to improve health outcomes, to ensure availability of and access to quality health services, and to support greater control of the health system by First Nations. Therefore, FNIHB's strategic approach is consistent with the over-arching federal government strategic objective and long-term plan to transfer delivery and administration of health care programs to First Nations control.

When it was created in 2000 (replacing the previous Medical Services Branch of Health Canada), FNIHB assumed responsibility for a range of specific programs for First Nations and Inuit health including children's program. Specific programs had been introduced to address identified health needs. Although evaluations of individual programs had found that they were performing well in responding to the health needs, concerns had been raised by federal central agencies (including the Auditor General of Canada) about the administrative efficiency of the range of individual programs and called for streamlining of reporting requirements for First Nations that were responsible for program delivery.

The 2004 program review process and introduction of the program activity architecture provided the opportunity to move toward a more integrated approach in community programs to link activities to results, and FNIHB developed a concept of a systems approach through the grouping of individual program mechanisms into 'clusters'. The CY Cluster grouped programs for children into an integrated strategy tied to the overall result of improved health for young First Nations children. [78]

Beginning in 2004, there were also on-going discussions among federal, provincial officials and First Nations concerning the integration of federal health policies with provincial health care to create a seamless system for First Nations health. There was growing awareness of the 'downstream' effects for provincial health services of health needs in First Nations communities and the need for a more integrated health care system. As a result, in June 2008, Health Canada received approval of a mandate to negotiate new tripartite agreements on further devolution of the First Nations health system under a revised First Nations/provincial governance structure to harmonize health policies and transfer federal dollars for health care.

[78] Based on Interviews with FNIHB officials.

The first Tripartite Agreement has been established in British Columbia and negotiations are underway in 2009 in other jurisdictions. Once completed, the restructuring would continue the trend away from individual program by program budgeting and funding authorities. Based on interviews with FNIHB officials, the cluster approach may be viewed as a phase in the evolution to an integrated federal strategy on health for First Nations, and further consolidations of program authorities and the cluster structure may occur.

The revised cluster structure of FNIHB Community Programs was approved in March 2005 in the revised Terms and Conditions for the Community Programs Authority (Health Canada, 2005). [79] According to the CY Cluster RMAF (Health Canada, 2006), the programs and services of FNIHB were streamlined in 2004 into 5 main contribution authorities to support the achievement of the overall Branch objectives, namely:

- Community programs;
- Health protection;
- Primary Care;
- Supplementary Health Benefits; and
- Health governance/infrastructure.

Within Community Programs, three 'clusters' of programs and services were created as part of the program review process in 2004. These are:

- Children and Youth Cluster (CY Cluster);
- Mental Health and Addictions Cluster; and
- Chronic Disease and Injury Prevention Cluster.

The CY Cluster was 'created in an effort to streamline and coordinate programs that are holistically [80] integrated at the First Nation community level for a comprehensive approach to program delivery, a simplified delivery and administration of programs, and an increased transparency. (CY Cluster RMAF, 2006) The 2006 CY Cluster RMAF states that the CY Cluster 'aims to improve the mental, physical, emotional, and spiritual health of First Nations individuals, families and communities.'

In 2004, the CY Cluster included three programs: AHSOR, CPNP and FASD. [81] The Maternal Child Health Program was subsequently added to the CY Cluster in 2005. Some of the CY Cluster services and programs are similar to those provided by provinces to their residents, although the CY programs rely more on trained community workers than health professionals. Some are similar to those provided to other Canadians through the Public Health Agency of Canada such as the Canada Prenatal Nutrition Program (CPNP) and Aboriginal Head Start.

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[79] The Terms and Conditions for Community Programs Authority were approved March 21, 2005, and subsequently updated May 31, 2055 and February 3, 2009.

[80] The RMAF defined 'holistic' as 'pertaining to a perspective toward health and social development which considers and incorporates the spiritual, cultural, physical and social needs of individuals, families, and communities in the provision of health care.'

[81] According to the Terms and Conditions for Community Programs Authority (Health Canada, 2005, the CY Cluster also included the Jordon's Principle Responses (Page 6-7). Jordan's Principle allows Health Canada to fund goods and services for First Nations children where there is uncertainty over which jurisdiction should fund them.

The CY Cluster children's programming through FNIHB is consistent with the overall policy approach of community-based and community-delivered programs and services. The federal government role through the FNIHB of Health Canada has included implementation of funding agreements with First Nations and Inuit communities, and provision of funding.

The health funding arrangements depend on program delivery partnerships with First Nations communities and organizations, and with P/T and other health organizations. Given the diversity of interests, health needs and capacities, FNIHB has a variety of agreements for the administration and management of First Nations community health programs and resources.

Four funding models have been developed to provide flexibility and varying degrees of control, authority, reporting requirements, and accountability. While federal funding is provided on the basis of the four CY programs in the Cluster, at the community level, programs are holistically integrated through community-based and community-delivered services. Under the overall governance structure, Health Canada and the FNIHB headquarters are responsible for the policy and program development for the services within its mandate, while FNIH Regional offices are responsible for implementation of programs and services under the various funding arrangements with First Nations and other organizations.

First Nations are responsible for the delivery of services and programs in their communities. Responsibilities are defined under the terms and conditions of Contribution Agreements with the First Nations involved. Reporting and accountability requirements associated with funding allocations may vary as defined in these agreements. However, FNIHB has overall responsibility for accountability and reporting on the use of federal funding under the various programs and activities.

Regional variations in FNIHB expenditures result from several factors such as the First Nations population distribution, the numbers of reserves in each region, the remoteness and isolation of communities, the health status of the population, as well as the legal and intergovernmental arrangements in place. Funding arrangements also vary under the various CY Programs. In some cases, such as the Maternal Health Program, funding allocations are made on a project/proposal basis. In other instances, funding may be allocated on a per capita basis in some Regions (e.g. CPNP).

The CY Cluster is consistent with overall federal government responsibilities as related to the Indian Health Policy, and subsequent developments in the evolution of the roles of governments and First Nations. These responsibilities in the area of health have been repeatedly acknowledged by all parties. In addition, both the federal government and First Nations have identified the priority of children's health needs in relation to early childhood development strategies as well as health and wellness based on a holistic approach.

FNIHB of Health Canada is providing children's programming through a community-based model that creates flexibility for First Nations to adapt services to the health needs of their communities. Notwithstanding the growing role of First Nations in health program planning and delivery, the federal government has an on-going role in the overall governance of and accountability for program funding under the various funding models. The roles and responsibilities of the various parties in health are expected to continue to evolve with the development of the tripartite agreements over the coming years.

The CY Cluster clearly relates to the overall federal role and mandate prescribed in the Indian Health Policy, and to FNIHB's strategic role in assisting First Nations to improve health. The 'cluster' approach has streamlined the program-by-program approach used in the past, and paves the way for further harmonization of children's health strategies, with a declining federal role in 'programs' and increased flexibility for use of federal funding on a cluster basis.

6.2.1. Findings on the Nature of the Federal Role

Findings 9
Evaluation Sub-question R3.2

The detailed findings on the appropriateness of the Cluster to the government's core roles are:

- As part of FNIHB's Community Programs, the CY Cluster is administered so as to contribute to the overall mandate of FNIHB in assisting First Nations to address health barriers and attain health levels comparable to other Canadians.
- Development of the integrated CY Cluster since 2005 is consistent with longer term trends towards devolution of delivery responsibilities, and development of the Tripartite Agreements for First Nations health care delivery.

6.3. Summary of Principal Findings, R3

Evaluation Questions	
R3.	To what extent is this cluster appropriate to the federal government and a core federal role?

Using the detailed findings for evaluation sub-questions R3.1 and R3.2, the principal findings to evaluation question R3 were developed and are presented on the following page.

SUMMARY OF PRINCIPAL FINDINGS FOR EVALUATION QUESTION R3

The principal findings relative to the Cluster and the Federal Government's role and priorities are:

- The CY Cluster is appropriate to the federal government and a core federal role to address First Nations health. Individual program components and the CY Cluster are consistent with the goal of the Indian Health Policy and the federal roles in public health and health promotion. The federal government is continuing to implement the long-term plan to transfer delivery and administration of health care programs to First Nations control.
- As part of FNIHB's Community Programs, the CY Cluster is administered so as to contribute to the overall mandate of FNIHB in assisting First Nations to address health barriers and attain health levels comparable to other Canadians, by building strong partnerships with First Nations to improve the health system. Development of the integrated CY Cluster since 2005 is consistent with longer terms trends toward increasing devolution of delivery responsibilities, and development of the Tripartite Agreements for First Nations health care delivery.

Section 7. EFFECTIVENESS IN MEETING HEALTH NEEDS

This section presents the analysis and findings for the fourth of the eight evaluation questions.

Table 27: Evaluation Issues and Evaluation Questions

Evaluation Issues	Evaluation Questions	
Relevance	**R1.**	Does the CY Cluster address clearly identified health needs of FN children and youth?
	R2.	To what extent is this cluster linked to a Government priority?
	R3.	To what extent is this cluster appropriate to the federal government and a core federal role?
Effectiveness	**E1.**	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?
	E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?
	E3.	Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?
	E4a.	Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
	E4b.	Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

To address evaluation question E1, the evaluation considered the extent to which the CY Cluster as a whole is meeting individual health needs. It examined participation in CY programs, access to services, the quality of CY programs, and the effectiveness in improving awareness and practice of healthy behaviours. It did not evaluate the contribution of individual programs within the cluster.

In all of the following sections addressing the effectiveness evaluation questions, data is presented from the three surveys conducted for this evaluation. The data from the Community Staff Survey and the Program Participants Survey include information from respondents in the 37 site visit communities identified in the introduction to this evaluation report. The limitations of these data were discussed in Section 3 on the methodology for the evaluation.

It is noted that these data cannot be extrapolated to all First Nations communities but are illustrative of community staff and program participant views in the range of 37 communities covered in this evaluation study. Therefore, in all tables and figures, the data identified as from "community staff" and 'program participants' should be taken to read as being from respondents to surveys in the 37 communities noted earlier in the report.

7.1. Participation in CY Programs (E1.1)

Table 28: Evaluation Sub-question E1.1

Evaluation Question	Evaluation Sub-questions
E1. Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?	**E1.1** Has participation of FN individuals in programs and supports, relating to CY programming, increased?

For purposes of the evaluation, ***participation was defined as the proportion of the eligible population that uses a program or service***. It should be noted that the definitions of the 'eligible population' impact on the participation rates. Since some CY programs are targeted to 'at risk' groups, it is difficult to determine the reach of the programs to the intended populations. Therefore, 'increased participation' is generally measured in terms of the absolute (total) numbers of participants. With increased CY funding during the evaluation period (for the MCH and the AHSOR enhancement), it is reasonable to expect that the numbers of participants would increase in the communities that received additional funding compared with prior years.

FNIHB's program performance reporting system provides some data on participation in CY programs for its CY Cluster Performance Reports. The 2008 CY Performance Report for the years 2004/5 to 2005/7 provided some data on the numbers of participants in CY programs. However, the Report notes that the data coverage varies from year to year, and that trends in participation rates are difficult to determine. It should also be noted that 'transferred bands' were not required to report on individual program activities under their contribution agreements under the old reporting system; they are now required to report. [82] Given the challenges of measuring participation rates, this evaluation relied on data compiled in the surveys of FNIHB and community staff on trends in participation in the CY cluster programs.

It is noted that participation is closely linked to the overall 'capacity' of the programs, that is, the numbers of mothers or children that can be provided with services and supports with the available staff and resources. All human services programs have finite limits to their program capacity based on their funding and staffing levels under any given service model. Capacity limits are discussed below, and evaluation data indicate that some or all programs are operating at full capacity in a majority of the communities surveyed for this evaluation. In these cases, increases in capacity and participation may not be achieved without reducing the levels or amounts of service provided to each participant. As noted in Section 4.2.2, community staff identified 'staff shortages' as the main barrier to access to services in their communities and also affect the 'quality' of services as discussed in Section 4.2.3.

The Surveys of FNIHB Staff and Community Staff included three indicators on trends in CY participation, namely: participation rates, requests for services, and programs at operating capacity, as shown in Table 29 that follows.

[82] FNIHB has a variety of contribution agreements that serve as vehicles for the administration and management of First Nations health programs and services. This is part of FNIHB's strategic direction to transfer control of programs to First Nations.

Table 29: Summary Indicators of CY Participation

Key Indicators	% FNIHB Staff (n = 23)	% Community Staff ** (n =118)
CY Participation rates increased in past 5 years: % Strongly Agree/Agree	72% *	NA
Requests for CY services:		
Increased in past 5 years	NA	73.6%
About the same		26.4%
Fewer requests		0
CY programs at full capacity:		
All programs at full capacity	NA	19.2%
Some programs at full capacity		55.8%
No programs at full capacity		25.0%

Sources: Survey of FNIHB Staff and Community Staff, 2009.

Notes: * 40% of FNIHB Staff responding said that they did not know. Percentage based on 60% of the FNIHB that provided an answer; and

** Percentages of community staff responses in 37 communities.

These data indicate the following:

- **Increased CY participation rates in the past 5 years**: at the overall Cluster level, 72% of FNIHB staff agreed that participation rates had increased in the past 5 years. However, some noted the lack of measures of participation.
- **Increased requests for CY services in the communities**: in the communities surveyed, 73.6% of community staff in CY programs said that they are receiving more requests for services now than 5 years ago, and 26.4% said it was about the same. No staff reported 'fewer requests' than five years ago. These data may indicate an increased demand for CY services and supports in many communities in recent years.
- **Capacity of CY programs in the communities:** in the communities surveyed, 19.2% of community staff in CY programs said that all their programs were operating at full capacity while 55.8% said that some programs were at full capacity and 25% said all programs could accommodate more participants. These data indicate that, in three-quarters of communities, there is limited additional capacity within existing CY programs to accept more clients and increase the participation rates in these communities.

It should be noted that at the Cluster level and in some communities, new programs and additional funding have been provided which would have contributed to increased numbers of participants served. However, participation rates are a function of both the supply of and demand for services, and the relationship between population growth and funding levels could not be determined due to lack of data.

The ability to increase participation rates within existing programs is a function of both the resources available, and the depth and breadth of services provided to participants. Responses from both FNIHB and community staff indicate that there is additional demand for services that cannot be addressed within the funding and capacity of existing programs, or to address increased volumes of need related to population growth. In addition, as noted earlier in this report, 33.9% of First Nations were funded for all CY programs in 2009. Therefore, participation rates can only be considered for the programs provided in individual communities. As noted in Section 7.2 below, 66.1% of participants surveyed in the 37 communities covered said that the services they needed are available in their communities.

Findings 10
Evaluation Sub-question E1.1

The detailed findings on participation rates in the CY programs are:

- Data available suggest that participation rates in the CY programs have increased in the past 5 years, in large part due to increased funding;
- The capacity of programs in the communities to further increase participation rates appears to be limited to human resources, limited space, and the lack of funding; and
- Further research would be required to quantify the capacity shortfalls to meet demand to reach the intended target or eligible populations.

7.2. Access to CY Programs (E1.2)

Table 30: Evaluation Sub-question E1.2

Evaluation Question		Evaluation Sub-questions	
E1.	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?	**E1.2**	Has access to quality programs and supports, relating to CY programming, improved?

The ability of clients to participate in the CY programs is influenced by various factors that may be perceived as barriers to service access. The evaluation surveys examined barriers to the access to CY programs and how these are changing as perceived by FNIHB staff, community staff, and participants themselves.

As the following definition indicates, funding limitations and service capacity were not defined as criteria affecting access of services. '*Access' was defined as ease of ability to use the service by the population (i.e. people have no transportation difficulties getting the service, there are no waiting periods, the service is available when people can use it, and it can accommodate their special needs, if any. Barriers to access were defined as transportation, waiting lists, hours of operation, accommodation for special needs that affect the use of the service by the population).*

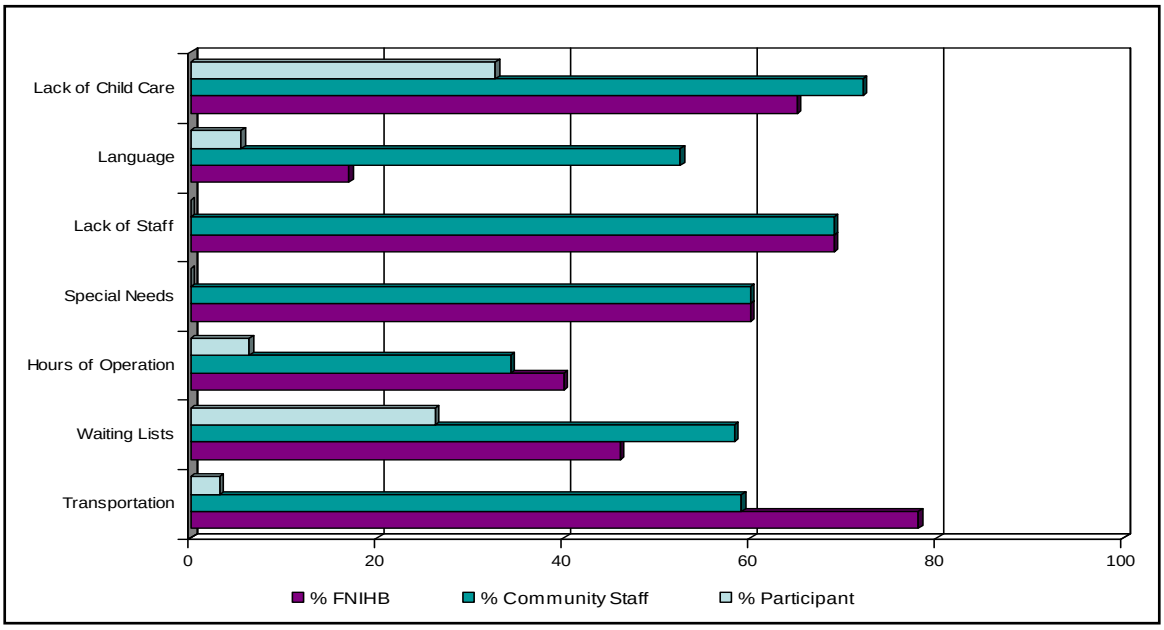
Figure 3 below summarizes the ratings of types of barriers to access from the three surveys. Multiple responses were possible each respondent in all three surveys (i.e. they were asked to rate each item identified as a barrier). Program participants were not asked to rate 'lack of staff' and 'special needs' as barriers in the questions.

The key findings from the survey data were as follows:

- **Most commonly identified barriers** affecting use of CY programs and services were transportation, lack of staff, and lack of child care. The barrier most frequently identified by FNIHB staff was transportation difficulties (78% of FNIHB staff). Lack of staff (68.8%), lack of child care (71.2%) and transportation (59.1%) were the three main barriers identified by community staff. Participants most often identified lack of child care (32.7%) as the main barriers, and only 3.1% said transportation was a barrier.

- Waiting lists were identified as a barrier by 58.3% of community staff and 40% of FNIHB staff identified 'waiting lists' as a barrier to access. [83] In the Participant survey, 26.6% said that they had been placed on a waiting list, most frequently for AHSOR services. Of those, 40.8% said they waited for less than one month, 38.8% said 1-3 months, and 20.4% said they were still waiting.

Figure 3
Ratings of Barriers to Access of Services



- Availability of the services in a First Nations language was rated as a barrier to access by 17% of FNIHB staff and 52.5% of community staff in the communities surveyed. On the other hand, only 5.4% of program participants said that the services were not available in their language. Among respondents to the survey of program participants, 55% said that they speak or understand their First Nations language, and 40% of these said that they use their language with their children. Therefore, availability of services in a First Nations language may be a barrier for some members of the community and not for other members.
- **Participants in CY programs most frequently identified lack of child care (32.7%) as the main barrier to service.** [84] A few community staff noted difficulties when their programs were expanded and the day care programs did not have enough full-day spaces, or in some cases, day care services were not available for infants (under one year of age). Only 3.1% of participants said that transportation was a barrier for them, which is much lower than the extent of transportation difficulties noted by community and FNIHB staff. The differences in these two numbers may indicate that the transportation difficulties of individual participants in the programs had been dealt with through other services available in their communities or with the assistance of

[83] Waiting lists are generally not reliable indicators of service demand owing to the variability in how service providers use the lists (if at all), the extent to which they are routinely updated, and the possibilities for applicants to be on several/multiple lists.

[84] These data include only actual participants in CY programs. No data are available on other potential participants that may have been unable to access CY services for any reason including the barriers identified in these surveys. Nevertheless, these data from participants do reflect some of the difficulties experienced in using the services in the communities.

family or friends. In comments in the surveys, some participants indicated that they rely on transportation from other people to access various services. Lack of services needed in the communities was reported by 33.9% of participants surveyed and 66% of these said that they had been referred elsewhere for the services they needed.

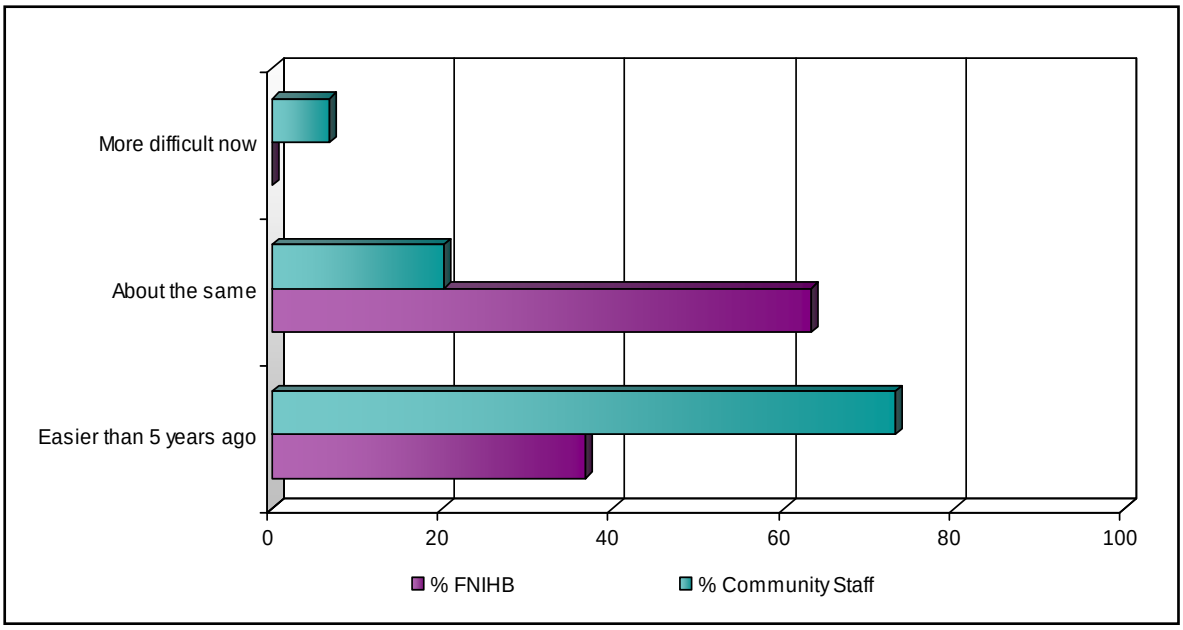
- **Special needs services were identified as an unmet need.** All three surveys included specific comments about the lack of services to assist children living with special needs. At the Cluster level, 68% of FNIHB staff said that there is lack of support for children living with special needs. In the communities, 60% of community staff surveyed identified lack of services for special needs as a barrier. FNIHB and community staff noted the lack of resources to provide the amount of additional assistance required to meet special needs over and above the 'regular' services delivered through the CY programs. In the participant survey, 6.8% of respondents said that there was a lack of services for their children living with special needs.
    - In comments in the survey, parents mentioned the need for support and advice on caring for children with autism, and on the need for respite care.
    - Parents who reported 'waiting for services' most often identified medical and other 'specialists' (including language and speech therapists) as the services they required. Most of the 'referrals' made when services were not available in the community were reportedly for various types of specialists.

It should be noted that the community staff were responding to the lack of specialized services in their communities and not to the proportions of children facing these difficulties. Although the numbers of children living with special needs may be small in any given community, the needs of the children and their parents are considerable and frequently require travelling to a larger centre to see specialists. This evaluation was not intended to 'quantify' the numbers of children and families that have children living with special needs.

Overall, these data suggest that there are challenges for the use of CY programs in many communities and for some program participants. Some CY and other programs include assistance to overcome specific barriers such as transportation and child care. It is not possible to determine the effects of these barriers on the participation of some eligible clients because measures of the effects are not generally available.

While access barriers were reported, survey data indicate that access to services has improved in the past five years as shown in Figure 4.

Figure 4
Improved Access to Services in Past 5 Years



At the overall Cluster level, 37% of FNIHB staff said it is easier now than 5 years ago for mothers and children to get the services they need. In addition, at the community level in the communities surveyed, 73.1% of community staff said that that it is easier now than 5 years ago for participants to get the services they needed.

63% of FNIHB staff and 20.2% of community staff said it was about the same as 5 years ago. While no FNIHB staff said it was more difficult, 6.7% of community staff said that it was more difficult now than 5 years ago for participants to get the services they needed.

7.2.1. Findings on Access to CY Cluster of Programs

Findings 11
Evaluation Sub-question E1.2

The detailed findings on access to the CY cluster of programs are:

- Access to CY programs has improved overall and in some communities over the past five years making it easier for mothers and children to get the services they need.
- Based on these data, continuing barriers to access include transportation, child care and staffing levels in the communities, and for program participants the major barrier reported was lack of child care.
- Both FNIHB and community staff identified lack of services for children living with special needs as a key concern. Even though the numbers of children living with special needs may be small in any given community, the severity of their needs and the difficulties of accessing specialized services in a larger centre can be major barriers for the families concerned.
- Further research would be required to quantify the special needs problems and services required.

7.3. Quality of CY Programs (E1.3)

Table 31: Evaluation Sub-question E1.3

Evaluation Question	Evaluation Sub-questions
E1. Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?	**E1.3** Are the programs and supports, relating to CY programming, of quality?

Four sources of information were used to assess the 'quality' of programs and supports to the people served by the CY Cluster, namely:

- **Survey of FNIHB Staff:** ratings of the overall Cluster level 'quality' defined as a standard of service delivery that is based on recognized practices of Health Canada, FNIHB or provincial standards or guidelines such as operational standards for child/staff ratios, dietary standards and guidelines, etc.. In some cases, recognized standards of service may be related to the professional accreditation of certain service professionals.
- **Survey of Community Staff**: ratings of service delivery to clients at the community level based on indicators such as the ability to respond, frequency of meetings and time with clients, and helping to refer clients to services.
- **Participant Survey**: ratings of the participant satisfaction with the services provided to them in their communities.
- **Training & experience of community delivery staff**: information on the qualifications and length of time staff have worked delivering CY programs in the communities.

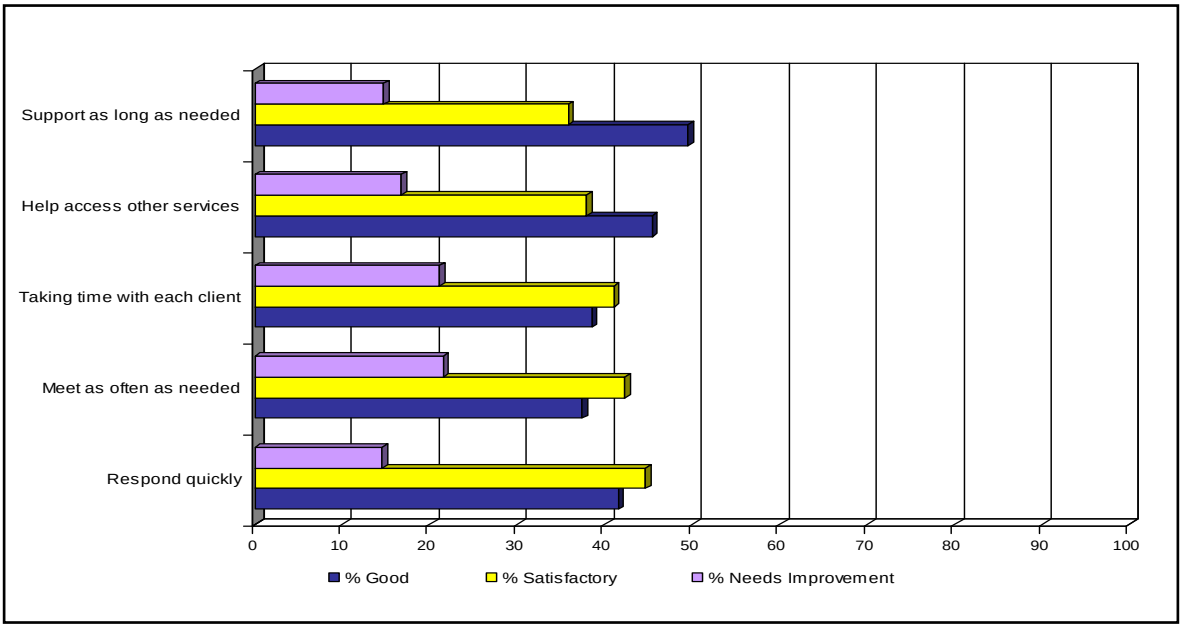
These four sources of information cover different aspects of overall 'quality' from different perspectives and provide a complementary set of indicators on this evaluation sub-question.

The FNIHB National and Regional staff provided the following overall ratings at the CY Cluster level:

- About half of FNIHB staff surveyed (56%) said that the CY Cluster overall provides quality programs and services.
- Comments in the survey of FNIHB staff noted practical challenges in the delivery of programs and services in some communities such as the lack of space and facilities for programming as well as program supplies within the funding available. In some cases, it was noted that sharing of staffing and other resources has enabled communities to provide services more effectively and efficiently. However, funding was not always sufficient for efficient program delivery, and there were limited opportunities to access additional funding from other sources.
- Other comments highlighted the importance of community health planning to address community health needs and access of other services close to many First Nations where clients could be referred for other necessary supports. With respect to FASD and other disorders, the lack of diagnostic services was identified as a barrier that leads to long waiting periods for many families and children before their health needs can be determined. Some people identified the need for specific screening and diagnostic tools to identify clients' health needs.

The ratings of service quality at the community level were based on the Survey of Community Staff in the 37 communities covered as shown in Figure 5. The survey asked staff to rate their services as 'good', 'satisfactory' or 'needs improvement'.

Figure 5
Community Staff Ratings of Quality of Services



The standards of services described in the survey questions included the following criteria:

- Responding quickly to client health needs or crises;
- Meeting as often as needed with clients;
- Taking the time needed with each clients;
- Helping the client to access other services (both CY programs and other services); and
- Providing support as long as it was needed by the clients.

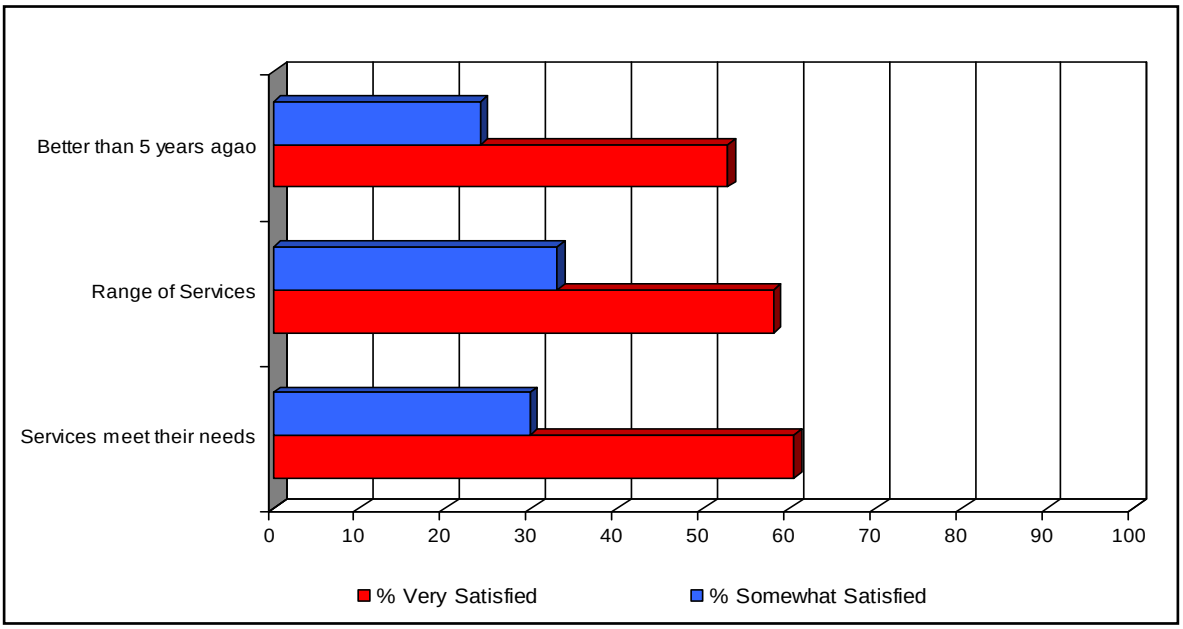
Based on these criteria, the key findings are as follows:

- Services were rated as 'good' or 'satisfactory' by about 80% of community staff and;
- The areas most often seen as needing improvement were: 'meeting as often as needed with each client' and the 'amount of time spent with each client'. These two indicators relate to the amount of staff resources available, and are consistent with community staff response on barriers to service access discussed in the previous section. Shortage of staff resources were identified as the main barrier to service by 68.8% of community staff.

Participant satisfaction with the services received is another indicator of service quality (from the user perspective). Data from the Participant Survey included three indicators are shown in Figure 6, and indicate that:

- 89.7% were very satisfied or somewhat satisfied with the programs in meeting their health needs;
- 91% were very satisfied or somewhat satisfied with the range of service available for mothers and children from prenatal to age 5; and
- 75.9% said there was a better or somewhat better range of services now than in the past.

Figure 6
Participant Satisfaction Ratings



These ratings are consistent with high client satisfaction ratings on services in satisfaction surveys (generally in the range of 85-90%). Various factors affect user ratings of satisfaction, and these data should be used in combination with other measures. [85]

The evaluation also considered staffing as a factor affecting delivery of quality programs and services. In the survey of FNIHB staff, many respondents identified staffing issues such as lack of trained staff with the necessary expertise, staff turnover, and interruptions in funding as factors affecting the delivery capacity at the community level. On the other hand, some noted that, where communities had developed collaborative working arrangements among the program staff, the quality of services provided were enhanced. The Survey of Community Staff collected information on the qualifications and experience of staff in the children's program areas on three indicators as follows:

- **Number of years of experience in CY programs:** more than half (53.2%) of the community staff surveyed had worked on the programs for more than 5 years, 19.8% for 3 to 5 years, 19.8% for 1-2 years, and 7.2% for less than one year. [86]
- **Amount of working time on the CY programs** (that is, the extent to which staff work part-time or full-time on the programs): 35.1% of staff work on CY programs over 75% of the time, whereas about 31.5% were part-time (work less than half time on these programs). There is some variation related to the size of the communities which also relates to the amount of program funding available, that is, smaller communities are less likely to have full-time staff on a specific program.

[85] Survey research methodologies suggest that factors include: client concerns about continuation of services or need for services in the future, loyalty to service delivery staff, waiting lists to access services, and so on. These data should not be interpreted as meaning that all client needs are effectively addressed.

[86] These data may under-represent the proportion of staff with less than one year's experience since the surveys were targeted to staff with more than one year's experience so that they would be knowledgeable enough to answer the questions.

- **Qualifications related to the CY programs:** two-thirds of staff said they have some related professional qualifications training including nursing (23.3%), child care (30.2%), social work (8.5%), and education (10.3%). Nearly a third (31%) said they had more than one professional qualification.

These data from the site visit communities suggest that program delivery staff are experienced, tend to work full-time on the programs, and most have related qualifications. A more in-depth study was conducted by FNIHB to independently assess the levels of training specifically related to the CY program areas, and the findings are summarized in Section 10 of this evaluation report.

Finally, an additional aspect of the suitability of the CY programs is the extent to which they incorporate culturally-relevant approaches (such as use of activities, materials and processes that reflect the language and culture of the communities). Eighty-five percent of FNIHB staff said that the CY programs use culturally-relevant approaches. In the communities covered, 45% of community staff said that their programs incorporate the teaching of First Nations languages, and 39.3% said that they incorporate traditional beliefs, teaching, and values. Data from the Participant Surveys indicate improved awareness of cultural and language issues among participants as reported in the section on awareness and practice of key behaviours.

7.3.1. Findings of the Quality of the CY Program

Findings 12
Evaluation Sub-question E1.3

The detailed findings on the quality of CY programs are:

- The CY Cluster is moderately effective in providing quality programs.
- Based on the respondents in the communities covered, the services provided are highly rated by the people served in the CY programs.
- Community delivery staff in the communities covered have qualifications related to the programs delivered, tend to work full-time in these programs, and the majority have several years of experience in these areas.
- Community staff face several challenges in providing the amounts and depths of services to meet the health needs, most notably related to the staffing levels which are associated with the funding available in local communities.

7.4. Awareness of Healthy Behaviours (E1.4)

Table 32: Evaluation Sub-question E1.4

Evaluation Question		Evaluation Sub-questions	
E1.	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?	**E1.4**	Has awareness of healthy behaviours related to CY programming increased in CY program participants?

The CY programs are intended to provide information and supports that can increase awareness of key factors affecting child health and development and lead to the adoption of healthier behaviours and, in the longer term, to better health outcomes. Improving understanding and awareness of healthy behaviours is a key first step and a key evaluation question was the extent to which the CY Cluster increases awareness of healthy behaviours among program participants. [87] This question was investigated in the 37 site visit communities and both community staff and participants were asked to rate the contribution of information received to awareness of a range of health issues.

The profiles of community staff and program participants responding to the surveys (presented in Section 3.5) show that there is a broad cross-section of respondents among the types of CY programs. At the time of the survey:

- Nearly 41% of participants were enrolled in the AHSOR;
- Nearly 47% were receiving CPNP;
- 31% in the MCH program;
- 6% in the FASD program; and
- Nearly half the participants responding said that they were receiving services from more than one program.

With the lack of data on the numbers of participants in the four CY programs it is not possible to assess the representativeness of this profile of program participants who participated in this survey. Similarly, community staff work in a variety of programs in their communities. At the time of the survey, 48% of the respondents worked in AHSOR. 45% were working in CPNP, 44% in MCH, and 24% in FASD. 62% of community staff said that they worked in more than one of the CY programs.

These data suggest that both program staff and participants surveyed include a cross-section of the people involved in the four CY programs who could be expected to be knowledgeable about the range of behavioural indicators included in the survey. This increases confidence in the data and coverage of the range of healthy behaviours.

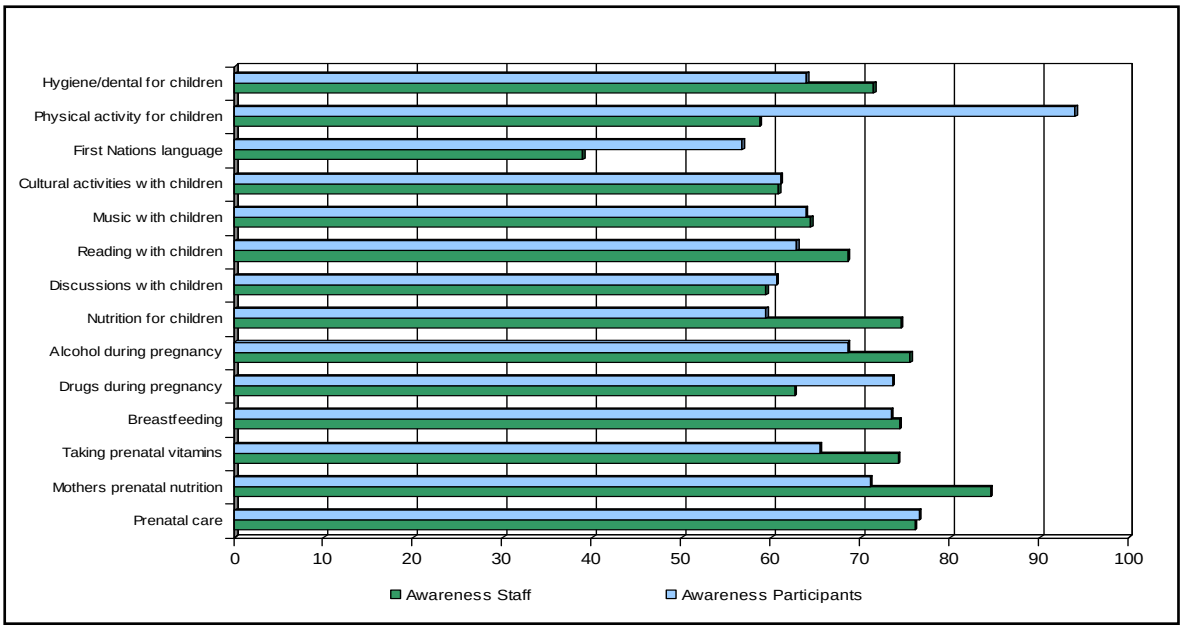
The survey questions were structured to allow respondents to answer only those questions that were relevant to them by answering that they did not know or did not receive information in specific areas. In the analysis, all of the 'Do not know' responses and respondents who said they did not receive information were excluded from the tabulations of results.

Figure 7 summarizes the awareness of healthy behaviours as identified by FNIHB staff for the CY Evaluation and demonstrates two measures of improved awareness of the specific behaviours:

- Community staff ratings of improved awareness among program participants
- Participant ratings of their own improved awareness

[87] It is recognized that people obtain information from a wide range of sources aside from the CY programs. In order to assess the link of improved awareness to the CY programs, participants were asked questions about the contribution of the program information to their understanding of health risks and issues. The evaluation design did not include comparison group methods.

Figure 7
Improved Awareness of Healthy Behaviours



The key findings from these data collected from community staff and program participants in the 37 communities are as follows:

- The CY programs are perceived as increasing awareness on all indicators by the majority of both community staff and participants. Overall, 60 to 80% of community staff report increase awareness on most of the indicators, and between 60 and 75% of participants said they were much better informed in most areas as a result of the information and support they received.
- Increased awareness is rated higher on some indicators than others. The highest ratings among community staff (84.5%) were for mothers' prenatal nutrition and prenatal care (76%). Among participants, the highest ratings were for physical activity for children (93.9%), breastfeeding (73.4%), and use of drugs during pregnancy (73.5%).
- The lowest scores were for First Nations language (38.9% of community staff and 56.7% of participants). The next lowest ratings by community staff were for physical activity (58.7%) and having discussions with children (59.4%). The next lowest ratings by participants were for child nutrition (59.4%) and having discussions with children (60.8%).
- Community staff was more likely than participants to report increased awareness on indicators such as child nutrition, mothers' prenatal nutrition, and alcohol use, and oral/dental care. On the other hand, participants were more likely than community staff to report increased awareness on the use of drugs during pregnancy and physical activity for children.

Overall, these data suggest that the CY programs were more effective in areas of maternal prenatal care than in areas related to child nutrition and early childhood development.

These data indicate that the CY programs and services have increased awareness of the majority of program participants across the broad range of indicators used in the surveys. Although there are some variations between the ratings of community staff and program participants on specific indicators, the ratings of both groups of respondents show substantial improvements in awareness across the indicators.

There are some variations among the healthy behaviour areas examined with generally higher scores on awareness of maternal health than on child nutrition and development indicators. Evaluating the effects at the Cluster level includes all four CY programs and individual programs were not evaluated. However, the individual programs have specific objectives that focus on particular areas of concern. For example, AHSOR focuses on areas related to child development whereas CPNP focuses on areas related to maternal pre-natal and post-natal health, breastfeeding and nutrition. Therefore, the measures of increased awareness may be affected to some extent by the program services received by participant.

In interpreting these findings, as noted above, it is recognized that people obtain information from a wide range of sources, including but not limited to the CY programs. The extent of improved awareness is a function of the pre-program understanding and knowledge about the specific health-related areas. Without pre-program measures of program participant awareness it is not possible to measure improved awareness directly. Therefore, these surveys relied on respondent recall and opinions about the effects of the information received through participation in these programs. In comments on the surveys, many participants provided positive comments about specific programs and services received, indicating a close link between the services provided and the value of the service to them.

At the same time, some participants noted that they felt they were knowledgeable about certain areas so that the information they received through the programs was just somewhat helpful in reinforcing their understanding. Given this, 'perfect scores" (that is, 100%) for increased awareness would be unlikely in the areas examined. In addition, knowledge is cumulative and mothers who have had several children could be expected to have accumulated considerable knowledge over time, and the effects for 'first-time' mothers could be higher than for experienced mothers.

The group of program participants responding to this survey included a cross-section of mothers with close to a third being mothers with one child, but two-thirds had two or more children. Therefore, the data include a mix of mothers with varying ranges of experience and knowledge about certain areas. More in-depth research would be required to assess the effects of the programs on awareness for mothers at different phases of child-bearing and child-rearing.

Considering all of these factors, there can be a reasonable level of confidence that the data and findings reflect the overall effects on awareness of healthy behaviours *among a cross-section of participants in the CY programs* based on the information that they received from the CY Cluster as a whole within the 37 communities in the sample.

7.4.1. Findings on the Awareness of Health Behaviours

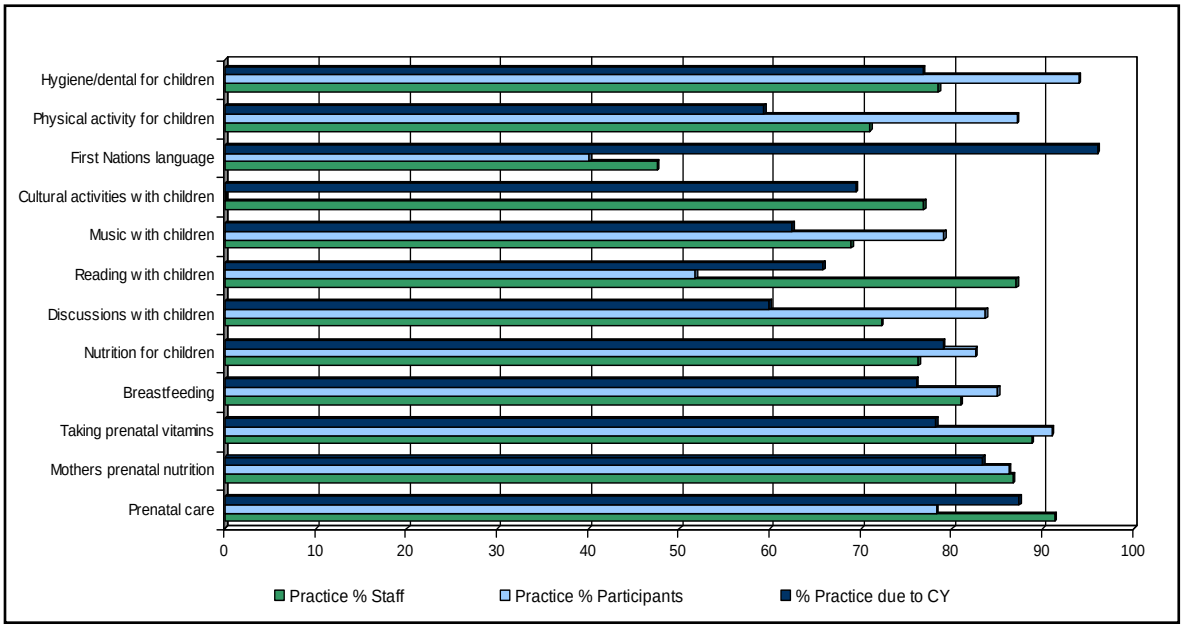
Findings 13
Evaluation Sub-question E1.4

The detailed findings on Awareness of Healthy Behaviours are:

- The majority of both program staff and participants surveyed in the communities covered indicated that awareness of healthy behaviours has increased across a broad range of indicators based on the information received in the programs. Between half and three-quarters of program participants said they were much better informed in these areas as a result of the information they received.
- These data indicate more improvements in awareness in areas related to maternal pre-natal care and breastfeeding than in most areas of child nutrition and early childhood development which tended to be closer to 60% except for the area of physical activity for children.
- More in-depth research would be required to investigate variations in awareness among the various areas, across the CY programs, and for mothers at different stages of child-rearing.

7.5. Practice of Healthy Behaviours (E1.5)

Figure 8
Improved Practice of Health Behaviours



Note: While figure 7 addresses awareness about drug and alcohol consumption, the evaluators have not included those two health needs in figure 8. Community staff that work with pregnant women stated that the majority of their clients will not admit to alcohol or drug use. Many clients will state that they are aware of the impacts that alcohol and drugs can have on their babies, but they will not admit to taking drugs and alcohol during their pregnancy.

Community staff stated that after a period of time working with a pregnant client that the client may admit to taking alcohol and drugs. Staff believe that drug and alcohol consumption is probably twice as high as what their clients admit to. Some community staff believe that drug and alcohol consumption during pregnancy may be as high as 40% in their community, with only half that number admitting that they take drugs and alcohol.

The participant survey questionnaire, Technical Report #3, addresses alcohol and drug use. Only 1% of the respondents admitted to taking alcohol and/or drugs during their pregnancy, versus the 20% to 40% range identified by community staff.

Figure 8 above summarizes data for the practice of the same indicators of healthy behaviours discussed in the previous section using three measures:

- Community staff perceptions of the extent to which participants in CY programs practice the specific healthy behaviours
- Participants ratings of their own practice of the specific healthy behaviours
- Participant ratings of the extent to which their practice of the behaviours is due to the information they received from the CY programs

For the second measure, the survey of participants included a five point scale and asked if they practice specific behaviours 'all of the time', 'most of the time', 'sometimes', 'rarely' or 'never'. In the analysis, the responses on 'all of the time' and 'most of the time' were combined to recognize the practical challenges of practicing most behaviours 'all of the time'.

The third measure was included as a means of determining the 'attribution' of behavioural change to the information that participants had received from the CY programs. In the analysis, top two points on a five-point scale ('strongly agree' and 'agree') were combined into one percentage, and 'Do not know' responses were not included in the ratings. [88]

The data presented in Figure 8 combines the top two points on 5-point scales for questions related to the practice of healthy behaviours. These data suggest the following key findings:

- The CY programs are perceived as increasing practice of healthy behaviours on all indicators by the majority of both community staff and participants. On almost all indicators, 70 to 90% of community staff increased practice of the healthy behaviours of the participants, while 70 to 90% of participants said they practice the behaviours all or most of the time.
- Increased practice of healthy behaviours is rated higher on some indicators than others. Prenatal care (91.3%), taking prenatal vitamins (88.8%), and reading with children (87.1%) were rated highest by community staff. Among participants, the large majority said that they practiced hygiene/dental care with their children (98.2%), and taking prenatal vitamins (90.8%). The lowest participant ratings were for reading to children (51.8%). Comments in the surveys identified various reasons for difficulties in reading regularly with their children including the difficulties of finding time and the lack of reading materials for younger children.
- Breastfeeding initiation rates were close to 85% based on these data, and this rate is shown in Figure 8. This rate is close to the Canadian average for mothers who breastfeed for some length of time, and higher than the rate for First Nations women according to the 2002-03 RHS (64%). However, this rate overestimates the effect on the practice of breastfeeding, even though those who do breastfeeding often continue for a considerable period of time.
- The data suggest that only 30-35% of mothers continue breastfeeding for longer than six months. Based on the reported duration of breastfeeding, a considerable percentage of mothers stop breastfeeding in the first three months. Comments provided in the survey showed that the benefits and advantages of breastfeeding are well-understood which is consistent with the rate of breastfeeding initiation. However, some mothers reported difficulties in feeding their babies leading to them switching to formula feeding in the first weeks and months.
- The lowest perceived practice of healthy behaviours was use of First Nations languages with children. About half the community staff (47.6%) said there was an increased use of First Nations languages. Fifty-five percent of participants said they use a First Nations language themselves, and 74.4% of those participants said they use it with their child. Therefore, about 40% of the total participants surveyed report using their language with their child.

To assess the effect of combining 'all/most of the time' as the indicator, a separate analysis was conducted of the data using only the answers given for 'all of the time'. As expected the scores were lower in some areas such as maternal and child nutrition as well as most activities with children. However, the ratings on areas such as pre-natal care, taking prenatal vitamins, and breastfeeding initiation remained over 70% as did hygiene and dental care for children.

[88] Detailed tabulations of survey data were provided in the Technical Reports to FNIHB.

Attribution of improvements in practice of healthy behaviours to the CY programs and services is high. Participants were asked if their behaviours were related to information received through the CY programs, and 60 to 80% said that they 'strongly agree' or 'agree' that their behaviours were due to information they had received. Participants were more likely to link their behaviours to CY information and supports on the maternal health indicators than on the indicators for child development.

A separate analysis was conducted of the data using only the answers given for 'Strongly agree', and as expected, the scores were lower in most areas with 30% to 40% saying that they 'Strongly agree' that their practice of the behaviours was due to information they received from the CY programs. Therefore, the range of attribution for the practice of healthy behaviours could be considered to be 35% to 70% across these indicators.

As an additional indicator on the attribution of effects to the CY programs, community staff were asked if participants in the CY programs were doing better than other families in their communities who have not received services. Over two-thirds of community staff (67.7%) said that CY participants were doing better than other families in their communities, and 27.1% said they were doing 'somewhat better' than other families.

Other sources of information affect the practice of health behaviours. The information provided in the CY programs is one of multiple formal and informal sources of information available to mothers and families about child health and development. For example, mothers generally receive information from health care professionals during and after pregnancies. In addition, the availability of child care in many communities means that there is additional information on child development, and people generally receive considerable advice from family members and friends on a range of child health and other issues.

This evaluation did not investigate all of these other sources of information, and comments in the surveys indicate that some people were informed about these issues before participating in the CY programs. Therefore, it would be unreasonable to expect that 100% of the practice of a given behaviour would be related to the CY programs. Even with the other sources that may be available, the attribution of the practice of healthy behaviours to the CY programs and services indicate that the CY programs are contributing to the practice of specific behaviours.

As in the analysis of awareness, there are some variations among the indicators with higher ratings on areas related to maternal health than on child nutrition and most child development indicators, although physical activity and hygiene/dental care were rated highly.

Interpretation of these data is affected by similar issues discussed in the preceding section on awareness of healthy behaviours. However, considering all of these factors, there can be a reasonable level of confidence that the data and findings reflect the overall effects on practice of healthy behaviours *among a cross-section of participants in the CY programs* based on the information that they received from the CY Cluster as a whole.

7.5.1. Findings on the Practice of Healthy Behaviours

Findings 14
Evaluation Sub-question E1.5

The detailed findings on Practice of Healthy Behaviours are:

- Based on these data, between a half and three-quarters of program participants practice the healthy behaviours all or most of the time.
- Between 65% and 85% of community staff reported increased practice of the behaviours among program participants on these indicators. These views are supported by data from participants and suggest that the CY program information has contributed to increased practice of healthy behaviours to a considerable extent.
- The attribution of effects to information and supports received in the CY programs may be in a range from 35% to 70% across these indicators, with higher rates on areas related to maternal health than on some of the indicators related to child development.
- These data suggest areas for further improvement related to increased practice of reading with children and the use of First Nations languages. Comments on the surveys in areas related to nutrition indicated that the major barrier was the lack of adequate financial resources to cover the high cost of food.

7.6. Summary of Principal Findings, Meeting Individual Health Needs (E1)

Evaluation Questions	
E1.	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?

Using the detailed findings from each of the sub-evaluation questions E1.1 to E1.5, the principal findings to the evaluation question E1 were developed and are presented on the following page. There is one bullet for each of the evaluation questions.

SUMMARY OF PRINCIPAL FINDINGS FOR EVALUATION QUESTION (E1)

The principal findings on how well the CY Cluster is meeting individual health needs are:

- Participation rates in CY programs have increased in the past 5 years. However, the capacity of programs in the communities to further increase participation rates appears to be limited. Further research would be required to quantify the capacity shortfalls to meet demand or to reach the intended target or eligible populations.
- Access to CY programs has generally improved. In some communities it was easier for mothers and children to obtain the services they need. However, there appears to be continuing barriers to access such as transportation, child care and staffing.
- The lack of services for special needs was identified as a key concern by both FNIHB and community staff. Even though the numbers of children living with special needs may be small in any given community, the severity of their needs, and the difficulties of accessing specialized services in a larger centre can be major barriers for families concerned.
- Further research would be required to quantify the special needs problems and services required.
- The CY Cluster is moderately effective in providing quality programs. The services are highly rated by the program participants responding to the evaluation surveys in the selected communities. Many of the community delivery staff have qualifications related to the programs delivered. They tend to work full-time in these programs, and the majority have several years of experience in these areas.
- Over 70% of the community staff surveyed reported that they work on two or more of the CY programs. At the same time, community staff face several challenges in providing the amounts and depths of services to meet the health needs, most notably related to the staffing levels which are associated with the funding available in local communities.
- The CY programs and services have contributed to increased awareness for the majority of program participants surveyed in the communities covered across the broad range of indicators of healthy behaviours. Between one half and three-quarters said that they were much better informed as a result of the information they received.
- There are some variations in awareness among the healthy behaviour areas examined with higher ratings on maternal prenatal care and breastfeeding than on child nutrition and development indicators.
- More in-depth research would be required to investigate variations in awareness among the various areas, across CY programs, and for mothers at different stages of child rearing.
- The evaluation found that between one half and three-quarters of program participants surveyed said that they practice the healthy behaviours all or most of the time, and 65-85% of community staff surveyed also reported increased practice of these behaviours by program participants. The CY program participants surveyed reported that the CY program information had contributed to practice of healthy behaviours to a considerable extent.

  - The effects of the CY programs were more marked in areas of maternal health than in most areas of childhood development. Reading with children and use of First Nations languages were identified as areas for further improvement.
  - The major barrier to improving child nutrition was the lack of adequate financial resources to cover the high cost of food.

Section 8. EFFECTIVENESS IN WORKING TOGETHER

This section presents the analysis and findings for the fifth of the eight evaluation questions.

Table 33: Evaluation Issues and Evaluation Questions

Evaluation Issues	Evaluation Questions	
Relevance	**R1.**	Does the CY Cluster address clearly identified health needs of FN children and youth?
	R2.	To what extent is this cluster linked to a Government priority?
	R3.	To what extent is this cluster appropriate to the federal government and a core federal role?
Effectiveness	**E1.**	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?
	E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?
	E3.	Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?
	E4a.	Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
	E4b.	Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

In considering the effectiveness question E2, the evaluation examined the extent to which the CY Cluster as a whole provides a continuum of programs that work together through networking and collaboration. It did not examine individual programs within the cluster.

This section introduces and addresses the continuum of services. In this evaluation this means the coordinated network of services and supports to meet the multiple and changing health needs of children from pre-natal to age 6.

8.1. Continuum of CY Programs (E2.1)

Evaluation Questions		Evaluation Sub-questions	
E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?	**E2.1**	Has the continuum of pre-natal to pre-school programs and supports in FN communities, relating to CY programming, improved? If so, how?

The CY Cluster is intended to provide a 'continuum' of services and supports for maternal and child health before, during and after pregnancy up to age 5 (or 6 in some regions). ***A 'continuum' of programs was defined as a coordinated network of services and supports to meet the multiple and changing needs***

of mothers and children from prenatal up to school age. (It is noted that some CY programs also serve fathers and other caregivers.)

To assess the continuum of CY programs, the evaluation used indicators of the complement of the four CY programs and their relationship to other programs for children, and the extent to which this range of services and supports had improved over the past 5 years. The evaluation also investigated opportunities for, and barriers to, the improvement of the continuum of CY programs over the next five years. Data was collected from the FNIHB staff survey and from the community program staff in 37 community site visits.

In assessing the data, there is an important distinction between the overall design of the CY Cluster (as a policy and program instrument) and the implementation of the CY Cluster in First Nations communities. In addition, the effectiveness of the continuum at the participant level can be assessed based on data from the Participant Survey. Therefore, findings are presented at these different levels.

The survey of FNIHB staff provided the following assessments about the continuum of CY programs <u>at the CY Cluster level:</u>

- 50% of FNIHB staff agreed that the CY programs provide a continuum of services to meet the multiple and changing needs of mothers and children's health needs. 14% were neutral, 32% disagreed and 4% strongly disagreed. On a 0-100 rating scale, 52% rated the CY as providing a continuum. Comments on responses noted that there are various services but no guaranteed space which inhibits the ability to provide a continuum, and that some health needs are not being met, even though it is a step closer.
- 48% of FNIHB staff agreed that the CY programs provide complementary services to improve child health, 48% said 'somewhat, and 4% said no. Comments noted that the programs are complementary in 'policy' terms but not 'in practice' in all communities due to variations in the coverage of the individual programs.
- 29% of FNIHB staff said that the CY programs and other children's programs are complementary, 65% said they are somewhat complementary, and 6% said they are not complementary.
- 83% of FNIHB staff said that the continuum of CY programs has improved in the past 5 years (4% said it had stayed about the same and 13% said that they did not know because of lack of data).
- 100% said that there are opportunities to further improve the continuum.
- However, 87% said that there are barriers to improving the continuum of CY Programs.

Extensive comments were provided by FNIHB staff to explain factors affecting the continuum. These were grouped into several categories and ranked in order of frequency.

By far the most common barrier identified by more than half of the staff was **funding**. A variety of issues were identified by FNIHB regional staff including: coverage of CY program funding across communities, lack of budget increases to address inflation, funds transferable outside CY Cluster, and the program by program funding approach used in the past. [89] Other types of barriers identified were in the categories of program delivery (39%), jurisdiction (30%), planning (22%), and community (22%) issues.

[89] It should be noted that FNIHB is in the process of introducing cluster-based funding to replace the previous program-based approaches.

At the community level, the availability of the four CY programs varies considerably based on past funding for each of the four programs. The Community Staff Survey in the site visit communities found that:

- 62.5% of community staff said that there is a continuum of services at the community level;
- 49.5% of community staff said that the CY programs work well together and 46.7% said that the programs work somewhat well together; and
- 53.8% of community staff said that the CY programs work well with other programs and 40.7% said they work somewhat well with other programs.

With respect to change over the past 5 years, 73.7% of community staff said that the CY continuum has improved, and 84.1% said that clients are receiving a wider range of services today than in the past. Comments provided in the surveys indicate that the programs are delivered in an integrated manner in the communities to reach the priority health needs identified in the community.

At the participant level, the key findings are as follows:

- 58.1% of participants said they strongly agree that there is a full range of services for ages 0 to 5 and 32.9% said they somewhat agree; and
- 52.8% of participants said that the range of services has improved and 23.1% said that it had somewhat improved in the past few years.

These data indicate that there is a 'continuum' of CY programming to some extent at both the program and community levels. Over 80% of FNIHB staff, over 70% of community staff and over 60% of the participants agree that the continuum has improved over the past few years. Opportunities to improve the continuum exist, but there remain considerable barriers.

8.1.1. Findings on the Continuum of Programs

Findings 15
Evaluation Sub-question E2.1

The detailed findings on the continuum of services to children aged 0 to 6 provided by the CY programs are:

- At the overall program level, there is a continuum of programs in the CY Cluster, and 83% of FNIHB staff said that it has improved in the past 5 years. Some opportunities for further improvements in the continuum were identified, but significant barriers exist.
- At the community level, over 58.1% of community staff said there is a continuum and 73.7% said the continuum had improved in the past 5 years.
- Participants also said that there is full range of services (for ages 0 to 5) and 61% said that the range had improved.

8.2. Networking & Collaboration (E2.2)

Evaluation Questions		Evaluation Sub-questions	
E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?	**E2.2**	Has collaboration and networking, relating to CY programming, increased and improved? If so, how?

Networking and collaboration with the CY programs and between the CY Cluster and other children's programs affect the overall effectiveness of the programs. The evaluation examined the extent to which networking and collaboration have increased and/or improved over the past 5 years, and opportunities for further improvement.

These questions were considered on two dimensions:

- At two levels, that is, the overall CY Cluster level (based on the Survey of FNIHB Staff) and at the community level (based on the Survey of Community Staff in the site visit communities); and
- Within the CY Cluster programs and between the CY Cluster and other programs.

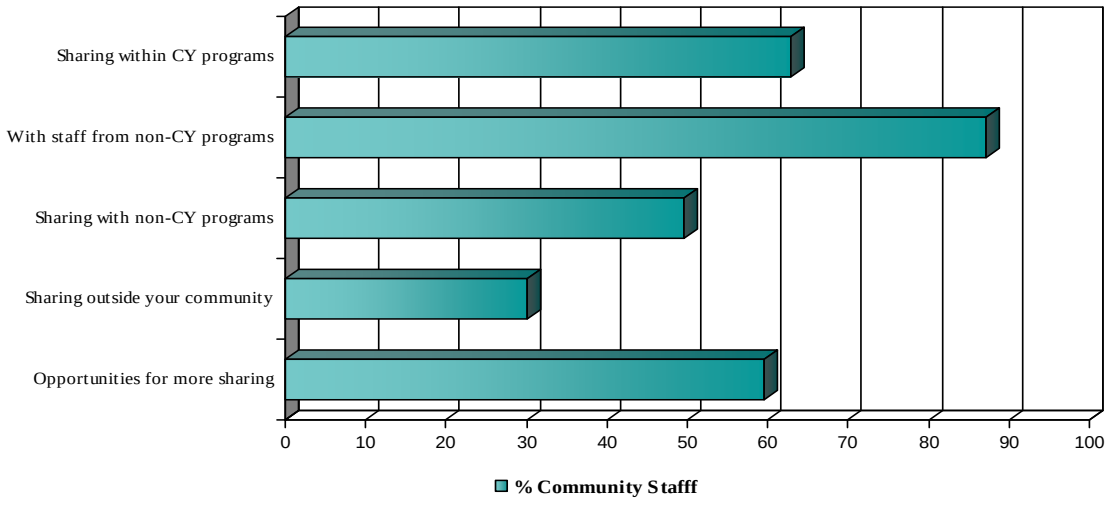
8.2.1. Networking

For purposes of the evaluation surveys***, networking was defined as sharing information among individuals, groups and institutions, and may involve both formal processes as well as informal working relationships.*** [90]

At the overall CY Cluster level, FNIHB staff reported that they are involved in regular meetings to share information (57% said one or more meetings per week), and that networking had increased at the national and regional levels in the past 5 years (77% and 90% respectively). Forty-two percent said that joint national/regional networking had increased but 24% said that it had decreased in the past 5 years.

At the community level, the extent of networking among the CY programs varied depending on the number of programs provided in the communities and the number of staff. In 22% of the communities included in the site visits, there were less than 5 staff in the community, and a few had only one or two staff persons. However, about a third of the communities had ten or more staff in their CY programs, and the majority of community staff reported considerable networking and information sharing as shown in Figure 9.

Figure 9
Information Sharing Within and Outside the Community



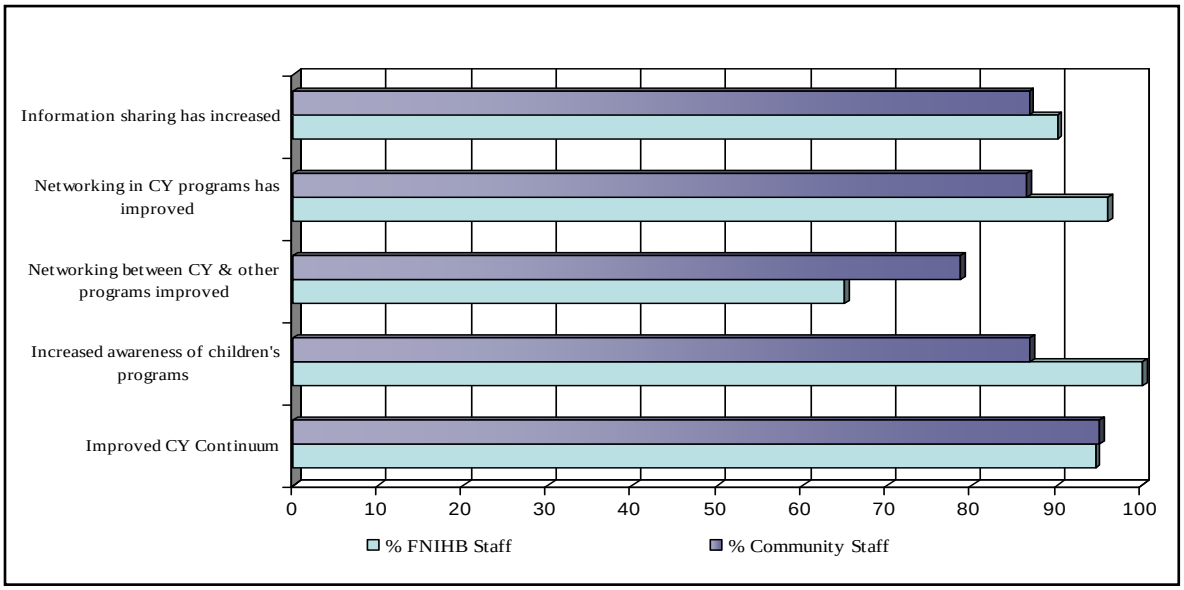
[90] It should be noted that the surveys included general questions about networking and did not investigate the types of organizations or events involved.

The detailed findings were as follows:

- 62.8% of community staff said there was information sharing very often or quite often among the CY program staff in their communities;
- 49.6% said there was information sharing between the CY programs and other (non-CY) programs, and 87% of community staff said they work with staff from other programs in their communities;
- 30% report information sharing between CY programs and organizations outside of their community; and
- 59.9% said there were opportunities for increased information sharing.

Both the FNIHB and Community Staff Surveys found that networking and information sharing was increasing and improving as shown in Figure 10.

Figure 10
Increased and Improved Networking and Sharing in Past 5 Years



At the overall CY Cluster level, more than 90% of FNIHB staff said that networking and information sharing among the CY programs had increased in the past 5 years, and that awareness of children's programs had increased. Considering networking between the CY and other programs, 65% said it had increased in the past 5 years. All of FNIHB staff said there were opportunities to further improve networking.

In the communities, 86.7% of community staff said that information sharing had increased over the past 5 years and 86.4% said that networking among CY programs had improved. In addition, 78.6% said that networking between the CY and other programs had improved, and 86.8% said that awareness of children's programs had increased in their communities in the past five years.

Information sharing and networking were seen as improving the CY services. Ninety-five percent of FNIHB staff said that the working arrangements with partners outside the CY programs had helped improve the continuum of service for maternal and child health. At the community level, 97% of community staff said that information sharing and networking were very helpful or somewhat helpful in delivery of the CY programs and improved the continuum of CY services.

Therefore, at both the overall Cluster and community levels, these data suggest high levels of networking and information sharing especially within the CY Cluster and to a somewhat lesser extent between the CY Cluster and other programs. Networking and information sharing have increased in the past 5 years and have improved the continuum of services, delivery, and awareness of the children's programs in the communities.

8.2.2. Collaboration

For purposes of the evaluation, ***collaboration was defined as the process by which FNIHB works together with key stakeholders and other F/P/T partners, involving them in decision-making in the design, development, and/or implementation of programs to take account of Aboriginal perspectives.***

At the overall Cluster level, FNIHB staff report high levels of and increasing collaboration. Given that the majority of FNIHB staff surveyed were from FNIHB regions, the majority (over 75%) said they were regularly involved in the implementation of CY programs whereas less than 25% said they were regularly involved in the design or development of the programs (which is undertaken at the national office. The majority of FNIHB staff were involved in development of collaborative agreements, joint programs, and sharing of resources as a result of their CY activities. For example:

- 87% said they were involved in informal joint projects and sharing of resources.
- 65% said there were more formal agreements (e.g. CAs, MOUs etc.). [91]
- 52% said there were more formal joint projects and more strategic alliances with NGOs and others.
- As well, 83% said that their work had improved recognition of Aboriginal perspectives in these types of programs.

Levels of collaboration were reportedly very good. For example:

- 73% of FNIHB staff rated the levels of collaboration among the CY programs as very good/good and 27% rate them as 'satisfactory. No-one said that they were 'poor' or 'very poor'. Most staff said that collaboration among the CY programs had improved in the past 5 years: 40% said 'much improved' and 50% said 'somewhat improved'. The remaining 10% said it was about the same, and comments indicated that there had always been some collaboration among the programs.
- 91% of FNIHB staff said that they feel there are opportunities to further improve collaboration among the CY programs over the next 5 years.

Follow-up questions asked FNIHB staff to provide examples of where opportunities for improved collaboration exist, and what are the main barriers over the next 5 years. The 'barriers' identified can be viewed as 'constraints' in achieving improvements. The main areas suggested for improved collaboration among the CY programs related to joint activities for CY programs (57%), and building on efforts to date to improve collaboration. Some respondents listed funding (13%), and there were a variety of other suggested areas.

[91] 'CAs' are Contribution Agreements, and 'MOUs' are Memorandums of Understanding. See Glossary of Terms for definitions.

The main barriers to improved collaboration among the CY programs were funding (43%), and issues related to the structure of the CY Cluster and programs (26%). The main funding constraint identified was the program-based funding used to-date. One respondent noted: 'The main barrier is that silos have occurred for so long, the mentality is difficult to break through.' Expressed another way, people identified 'resistance to change' and the need to change the 'structures' as impediments to collaboration.

Another response suggested the need for one unified CY approach, another saw lack of common goals as a barrier, and one commented on the divisiveness between national and regional levels and lack of cohesion. Many respondents make a link between the current program-based funding approach and the lack of a unified, cluster approach.

Other barriers identified included: resource and staffing limitations, unequal and inadequate community funding, time constraints, travel, and different regulations of different agencies. More than half the respondents identified these other types of barriers or constraints.

Overall, collaboration with partners outside the CY Cluster was seen as helping to improve the continuum of services for maternal and child health generally. Therefore, while there were opportunities identified for improving CY collaboration, there were also constraints related to the structures and processes of the cluster as well as wide ranging other issues that could impede improved collaboration. A key theme or message appears to be the need for more integrated or unified approaches to the CY Cluster as a whole, and more than half of the respondents saw opportunities to promote collaboration through more joint work.

This evaluation addressed the CY Cluster programs as delivered and funded over the past years and did not examine changes in funding approaches underway. Future evaluations will need to consider the new funding arrangements after they are implemented.

8.2.3. Summary of Detailed Findings (E2.2)

Findings 16
Evaluation Sub-question E2.2

The detailed findings on Networking and Collaboration are:

- Overall levels of networking and collaboration on the CY programs are good and improving at both the Cluster level and the community level. There is evidence of considerable collaboration among the four CY programs at the community level.
- In addition, there is networking between the CY and non-CY programs at the community level.
- Networking and collaboration are viewed as improving the continuum of CY programs and the delivery of services at the community level.
- Some areas for improvement were identified, although the constraints affecting increased collaboration were recognized.

8.3. Summary of Principal Findings, Working Together (E2)

Evaluation Questions	
E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?

Using the detailed findings for each of the evaluation sub-questions E2.1 and E2.2, the principal findings to the evaluation question E2 were developed and are presented on the following page.

SUMMARY OF PRINCIPAL FINDINGS FOR EVALUATION QUESTION (E2)

The principal findings on working together are:

- There is a continuum of programs in the CY Cluster to address maternal and child health needs for age 0 to 6 at the overall program level and in the communities. There is evidence from FNIHB and community staff as well as the participants surveyed that the continuum has improved in the past five years
- The continuum of programs is enhanced by networking and collaboration at all levels of FNIHB and in the communities. All the evidence suggested that networking and collaboration are good and improving at all levels. There is considerable collaboration both among the four CY programs and between the CY and non-CY programs at the community level. Some areas for further improvement were identified as were constraints to increasing collaboration.

Section 9. UNINTENDED OUTCOMES

This section presents the analysis and findings for the sixth of the eight evaluation questions.

Table 34: Evaluation Issues and Evaluation Questions

Evaluation Issues	Evaluation Questions	
Relevance	**R1.**	Does the CY Cluster address clearly identified health needs of FN children and youth?
	R2.	To what extent is this cluster linked to a Government priority?
	R3.	To what extent is this cluster appropriate to the federal government and a core federal role?
Effectiveness	**E1.**	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?
	E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?
	E3.	Are there any unintended positive or negative outcomes as a result of implementing the CY Cluster?
	E4a.	Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
	E4b.	Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

The third effectiveness question considered whether or not there were other unintended positive or negative outcomes [92] as a result of implementing the CY Cluster. The evaluation considered the extent of unintended outcomes for both program participants and for communities. This question was examined through open-ended questions in the surveys, and the responses were categorized through content analysis and are summarized in separate technical reports.

9.1. Positive Unintended Outcomes and Impacts (E3.1)

Table 35: Evaluation Question E3 (no sub-evaluation questions)

Evaluation Questions		Evaluation Sub-questions	
E3.	Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?	**E3.1**	Are there any unintended positive outcomes or impacts identified as a result of carrying out the CY Cluster?

9.1.1. Positive Outcomes Identified by FNIHB Staff

In the FNIHB staff survey nearly two-thirds of responded that they were not aware of any positive or negative unintended outcomes of the CY programs. One third of respondents identified various types of effects. Some responses dealt with factors affecting the CY programs.

Information gathered in the community site visits (from community staff and program participants) provided additional insights into some outcomes for program participants, their children and families, and for the community as a whole. In addition, a question was included for participants that deal with 'changes in their children's behaviour' to identify broader outcomes that were not addressed in the 'healthy behaviours' questions. A question was included for community staff that dealt with awareness of children's programs within the community.

Overall, 33% of FNIHB staff, 58% of community staff and 51% of participants identified types of 'unintended' effects in the surveys.

The FNIHB staff survey identified the following types of positive unintended outcomes:

- ***Improved effectiveness***: Owing to the limited program dollars, communities have had to develop collaboration across the program areas. This could be seen as improving the effectiveness of services within the funding available.
- ***Increased community awareness and planning***: The CY programs have made communities more aware of their service needs and their assets, and helped community planning based on their health needs. Community planning helps communities to look at their programs as a whole and not as 'stove-pipes'.
- ***Integration of traditional cultures***: The CY programs have fostered inclusion of traditions and cultures into some of the activities.

[92] Federal evaluation guidelines include consideration of unintended outcomes from federally-funded programs. Evaluations are expected to examine the extent to which programs result in any other positive or negative effects for individuals, communities or society as a whole. Any unintended outcomes need to be weighed against the positive intended effects of programs, and may need to be addressed through revisions to programs.

- ***Improved reach of services to non-status women:*** MCH is serving non-status women because their children have status. Previously, these women did not qualify for other services (e.g. transportation) but are now able to get assistance because MCH has taken this barrier away.
- ***Increased sharing of resources***: There is more sharing of resources across regional CY programs, more integrated events and workshops.
- ***Staffing & funding***: There is dedicated staff in the program areas (although some additional training in some areas could be beneficial).

The Participant Survey asked parents about the effects of their participation in the CY programs on their children's behaviours and their families, and found that 51% of participants said that their children's 'behaviour' had improved because of what they had learned in the programs.

Analysis of qualitative data [93] identified three main themes. Participants identified improvements in children's: (i) listening/obedience; (ii) socialization skills (getting along better with other children and adults); and, (iii) self-esteem, confidence and independence. Participants also identified improvements in their parenting skills and in parent-child communications.

Program participants also identified a range of other effects for themselves or their children. Analysis identified two main themes, namely: (i) improved parenting skills, and (ii) improved well-being of their children. Other effects included improved communications, parents learning discipline methods, and increased parents' involvement with their children.

9.1.2. Positive Outcomes Identified by Community Staff

During the site visits to the selected 37 First Nations communities, and after completion of the survey questionnaires, community staff members were provided the opportunity to discuss any program related topics and concerns that they believe should be of interest to the evaluation.

The field evaluators did not provide community staff with a list of topics or concerns for discussion. The topics and concerns were identified by the community staff. Those thoughts, ideas and concerns present a useful insight into the CY programs, and are presented in this section of the technical report.

More than half of the community staff stated that they already employed an integrated (cluster) approach for most of their health and wellness programs, which includes the CY programs. In those communities, staff worked at delivering an integrated program of services, with specialists being brought in to address specific health and wellness needs. They believed that a holistic approach was better for their clients.

For the CY cluster, community staff stated that CPNP, FASD and MCH were generally well integrated into their health and wellness programs, but that AHSOR tended to be managed independently.

Community staff stated that AHSOR was seen by many as an educational program designed to get the children ready for school. They also stated that the experience and qualifications required to work in the AHSOR program were very different than those in the health and wellness areas, and that most AHSOR staff were employed full time delivering AHSOR, and did not have time to work in other program areas.

Community staff stated that if the Cluster approach reduced reporting requirements and simplified program delivery by reducing the gaps between programs, then they were supportive of the process, but subject to their concerns (sub-sections 1.2 and 1.3) being adequately addressed and resolved.

Community staff asked if FNIHB were going to create clusters in other areas of their program delivery, and if all FNIHB programs would eventually fall under a single health and wellness program.

[93] See Technical Report #1 Qualitative Responses – Program Participants, ASA Inc., Report to FNIHB, 2009

9.1.3. Summary of Detailed Findings (E3.1)

Findings 17
Evaluation Sub-question E3.1

The detailed findings on unintended outcomes are:

- FNIHB staff identified: (i) improved effectiveness; (ii) increased community awareness and planning; (iii) greater integration of traditional cultures; (iv) improved reach of services to non-status women; and (v) increased sharing of resources.
- Communities are supportive of a more integrated approach to the delivery of a larger number of FNIHB's programs and services.

9.2. Negative Unintended Outcomes and Major Concerns (E3.2)

Table 36: Evaluation Question E3 (no sub-evaluation questions)

Evaluation Questions	Evaluation Sub-questions
E3. Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?	**E3.2** Are there any unintended negative outcomes, impacts or major concerns identified as a result of carrying out the CY Cluster?

9.2.1. Negative Outcomes Identified by FNIHB Staff

The FNIHB staff survey identified the following types of negative unintended outcomes:

- ***Community concerns about funding***: Given that funding was not enough for each community, there are misinformed assumptions about why communities did not receive more funding. This can cause problems between communities.
- ***Program interruptions negatively impact clients:*** Staff shortages and funding interruptions lead to program interruptions which can lead to client 'let-downs' when services are not available.
- ***Service gaps and health needs identified***: When clients 'open-up' about their issues, gaps in services available can become more apparent and increase strains on available resources.
- ***Targeting services can affect client behaviours***: Clients in crisis and facing serious basic issues for themselves or their children may be encouraged to seek ways to obtain or maintain their eligibility for particular services. An example relates to food security issues and the availability of food supplements for pregnant women. Women lacking other resources may say they are pregnant to receive food supplements, and/or be encouraged to become pregnant again to ensure continuation of food assistance.

- ***Strain on facilities and staffing in the communities***: Delivery of some programs is made difficult by the lack of space and facilities. The availability of program funding can put a strain on limited facilities in the communities. Staff turnover in programs puts a strain on the communities to deliver the programs available with their funding.

9.2.2. Negative Outcomes Identified by Community Staff

The Community Staff survey identified the following types of outcomes which had raised some difficulties:

- Increased demand for CY services had lead to longer waiting lists for other programs such as day care that could not be expanded with the funding available;
- There is a large demand for services and they would like to reach more mothers and children with CY services;
- Provision of services had raised expectations and had lead to some discussion about the need for fees for non-band members;
- Salary levels for the very qualified staff in the CY programs were not high enough because of budget limits;
- Some parents have been more willing to accept referrals to other services rather than accessing the supports through the CY programs in their communities due to privacy concerns; and
- Parents who receive services without a charge are not willing to complain about the services they receive.

There were additional comments in the Community Staff Survey concerning some of the 'logistical' difficulties with the facilities and materials to operate their programs.

Some of these issues may be addressed through improved communications about the CY programs and by increasing flexibilities for use of available funding at the community level. However, overall funding levels and structures for the CY Cluster as a whole are broader issues that need to be addressed at a more global level.

9.2.2.1. Clusters and Health Transfer Concerns

Some of the community staff, especially those who have been around for a while and/or have experienced the impact of FNIHB's health transfer policy of a few years ago, had concerns about FNIHB's plan behind the cluster-based approach. Other community staff stated that they were unaware of FNIHB's move towards cluster-based funding, and that they had concerns that this was signalling FNIHB's retreat from their communities, as had been the case with the health transfer policy.

9.2.2.2. Clusters and Funding Concerns

Responses from community staff in the evaluation survey indicate that the level of understanding about the 'cluster' approach varies from community to community. Some community staff, mostly at senior levels, expressed concerns that the move towards cluster-based funding could cause problems in communities that are currently funded for fewer than the four CY programs. They have concerns that, once cluster-based funding is established, it may not be possible to identify which communities were originally funded for one, two, three or four CY programs.

In addition, some community staff are concerned that, once cluster-based funding is initiated, community members will know that their community is now being funded for all four CY programs, creating expectations and a demand for services that cannot be met largely because of a lack of funding and the resources needed to deliver all four programs. Their concern is that a community (for example) currently receiving funding for two of the four CY programs, may be expected to deliver all four of the CY programs to their communities.

These concerns among staff in some communities may reflect a lack of understanding of the cluster approach and how the new funding arrangements will be implemented. They may indicate a continuing need for more information sessions with the communities.

9.2.2.3. PROGRAMMING FLEXIBILITY AND ESTABLISHING PRIORITIES

Community staff identified programming flexibility as both a strength and weakness of the CY cluster of programs. The strength is that communities are provided a fair amount of flexibility to adapt the program to the community's specific needs. The weakness is that FNIHB provides few examples of successful practices and approaches to address health needs; nor does it provide strong documented guidance as to what needs to be done.

Community staff went on to explain that larger communities have many areas of specialization and they are generally better able to identify and prioritize their communities' needs. Their travel budgets are also larger so they able to attend FNIHB and other seminars and workshops that address the delivery of health needs. Community staff also stated that FNIHB does not consistently document and follow-up seminars and workshops so that those communities that were unable to attend can benefit from the knowledge that was gained and shared.

Staff explained that small communities mostly have small health and wellness teams that are required to provide a range of services that often exceeds their collective and individual areas of expertise. The staff in many of the smaller communities need help to identify the range of health needs they should be addressing, and in some cases, there are health needs that are not being adequately addressed because some community staff are not aware of some health needs and how those needs should be addressed.

Community staff further explained that the high turnover of health and wellness staff in the communities, combined with high staff turnover in FNIHB's regional offices further complicated the challenge of identifying health needs because information was being lost.

Community staff noted that the current H1N1 public health crisis is an exception. FNIHB is stepping forward and providing direction and support to communities and documentation is being distributed and shared. It was felt that other health needs are just as important as H1N1 and that FNIHB should be making a significant effort to address them.

When asked if FNIHB was the only option for the provision of support and documentation to smaller communities: (i) some community staff noted that the gap could be filled by another organization, but that would just add another layer to an already complicated process; while (ii) most community staff stated that a First Nations health organization should be tasked with providing the support and documentation.

Community staff were in overall agreement that they did not want FNIHB to prioritize their health needs nor prescribe how the health needs are to be addressed, as each community must decide on the path they should take.

One staff member who had worked in a large provincial health agency stated that FNIHB does not have a structured approach to address health and wellness in the communities that is well documented and available to communities. Information arrives in a piecemeal manner, and that information is often lacking guidance and suggestions on how things are to be done. There does not seem to be a master plan to develop a health and wellness guide for use by communities. There seems to be a void in that there is no 'health and wellness' authority to provide guidance and support.

One Elder who had worked most of her adult life in the health and wellness sector summarized the situation by explaining that if smaller communities are not provided with useful direction and support, staff spend too much time wondering about what to do and how to do it, rather than focussing all of their time on helping community members.

9.2.2.4. NON-FUNDED COMMUNITIES LEFT AT THE SIDELINES

Community staff noted that communities not being funded by FNIHB to address health needs are being left at the side lines. Those communities, for the most part, because of a lack of funding, are not being invited to FNIHB training sessions, and they generally are not receiving support to address health needs. They went on to explain that while only a very small number receive no funding from FNIHB, most First Nations are not funded for all of the programs, and it is for those non-funded areas that they are not receiving guidance and information.

Some community staff questioned the benefit of providing program specific information to communities that are not being funded for one or more of the CY programs. In other words, why send MCH information to a community that is not receiving MCH funding?

Other community staff stated that with the clustering of CY programs, that FNIHB should be sending all information to all communities, regardless of whether they were funded for those programs in the past, or not.

One community staff stated that opportunities are being missed. If a community, for example, is not being funded for MCH, it is possible that elements of the MCH program (information etc.) could have been included within the delivery of other programs being delivered within the community.

9.3. Summary of Principal Findings, Unintended Outcomes (E3)

Evaluation Questions	
E3.	Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?

With the data available, it is not possible to determine if the types of outcomes discussed above are localized or can be generalized to different regions, other communities and/or to all CY programs. Nevertheless, the types of unintended outcomes identified suggest some implications for the CY Cluster as currently designed and delivered.

SUMMARY OF PRINCIPAL FINDINGS FOR EVALUATION QUESTION (E3)

The principal findings on positive unintended outcomes are:

- Delivery of CY programs as a group at the community level is seen as fostering integrated approaches to services planning and more effective delivery.
- Participation in CY programs leads to a wide range of positive effects for parents and children that go beyond the focus on 'healthier behaviours' themselves.
- CY programs are seen as fostering the inclusion of traditions and cultures into activities, and, and in some cases, to have improved the reach of some services to women who may not have qualified for supports under previous programs.

The principal findings on negative unintended outcomes are:

- Community staff are concerned about the potential impact of FNIHB's cluster approach and the potential for FNIHB's disengagement from health and wellness programming.
- Community staff are concerned that the cluster-based approach will cause in an increased demand for services that can not be met with current funding levels.
- Many communities, particularly smaller communities, need additional support on how to identify, prioritize and address health needs complete with suggestions and examples of how this might be done.
- FNIHB does not provide structured integrated practices and guidance documents to support communities planning for and delivering health needs services and support.
- Communities not funded for specific CY programs are not receiving information about those programs and thus are missing the opportunity to incorporate some of the elements into the other programs they are delivering.

Section 10. COMMUNITY OWNERSHIP AND RESOURCE CAPACITY

This section presents the analysis and findings for the seventh and eighth evaluation questions.

Table 37: Evaluation Issues and Evaluation Questions

Evaluation Issues	Evaluation Questions	
Relevance	**R1.**	Does the CY Cluster address clearly identified health needs of FN children and youth?
	R2.	To what extent is this cluster linked to a Government priority?
	R3.	To what extent is this cluster appropriate to the federal government and a core federal role?
Effectiveness	**E1.**	Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?
	E2.	Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?
	E3.	Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?
	E4a.	Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
	E4b.	Does the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

The evaluation considered the extent to which the CY Cluster as a whole contributes to increased First Nations ownership (E4a) and to increased human resource capacity (E4b) to deliver child health programs and supports. It did not examine the contribution of individual programs within the cluster.

The fourth effectiveness question included one sub-question as shown in the chart below. The evaluation used the indicator of First Nations' involvement in decisions about CY programming and services to address the question. The extent of First Nations involvement in decisions for the CY programs is affected by the funding arrangements or funding model applied. There are currently 4 types of funding arrangements with varying degrees of flexibilities. The evaluation considered factors affecting the ability of First Nations to enter into flexible transfer agreements.

10.1. First Nations Decision-Making for CY Programs (E4a.1)

Table 38: Evaluation Question E4a and its Sub-question

Evaluation Question		Evaluation Sub-question	
E4a.	Does the grouping of the children's program investments contribute to increased FN ownership to deliver child health programs and supports?	**E4a.1**	Has FN community ownership to deliver maternal and child health programs and supports increased?

The survey of FNIHB staff indicated that First Nations are more involved now than 5 years ago in decisions about the CY programs and setting priorities to meet community needs.

Two-thirds of FNIHB staff said there was more involvement and one-third said the First Nations were somewhat more involved now than 5 years ago.

Forty percent of community staff said that there was more community involvement in decisions about the programs than there was 5 years ago.

First Nations are directly involved in the planning stages to develop community health plans as well as in the program delivery. Depending on the funding model applied, some First Nations also have flexibility on the use of funding for the CY programs and for other types of programs in the community. If, after delivering their CY programs, communities have remaining funding, they may use the balance of the funds for another CY program (under the 'set funding' model), or for another CPD program (under a 'transitional' funding model), or for another cluster (under 'flexible funding').

10.1.1. Summary of Detailed Findings (E4a.1)

The information compiled from FNIHB staff and from staff in the communities covered in this evaluation suggests that there is increasing First Nations ownership to deliver maternal and child health programs.

Findings 18
Evaluation Sub-question E4a.1

Findings on First Nations Decision Making:

- There is increased involvement of First Nations in decisions about the programs in the past 5 years, in some but not all communities

10.2. Increased Human Resource Capacity? (E4b)

The fifth effectiveness question considered the extent to which the grouping of children's program investments in the CY Cluster contributed to increased human resource capacity to deliver children's programs in First Nations communities. It was examined through a separate study, the CY Training Review, commissioned by FNIHB from independent consultants and completed in October 2009. The findings and conclusions presented below were prepared by CYD staff.

Table 39: Evaluation Question E4b and its Sub-questions

Evaluation Questions	Evaluation Sub-questions
E4b. Does the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?	What are the training needs of FN CY programs? What training is being provided to CY staff at the community level Is the training offered aligned with identified needs? (Is training meeting the needs of FN CY program staff?) Are the Community Staff satisfied with training offered? How has training helped the community staff? i.e. Have they experienced an increase in confidence in skill level? Has the training offered changed staff composition by providing more trained/skilled workers? Have communities been able to offer different programs or components of programs as a result of training? Does any of the training offer culturally specific, relevant information/resources? What partnerships have been developed to provide training? Were these ongoing or one time?

10.2.1. Human Resource Capacity to Deliver Children's Programs

Most of the information provided in this section is based on a CY Training Review Report (2009) which surveyed a total of 93 community staff : 59 in Manitoba, 18 in Quebec and 16 in Ontario; as well as 7 FNIH regional managers from across Canada.

At this time it is not possible to determine if the information gleaned from community respondents in those three regions can be generalized to all regions, however, the responses from the Regional managers across the country appear to support the findings.

What are the training needs of FN CY programs?

The top two listed training needs identified by community respondents in a recently commissioned CY Training Review[94] survey were: management training (supervisory tips/human resource management) and working with special needs children and their families. In the same review, regional children's managers identified the most important training needs as: home visiting training (5 of 7 respondents), including more advanced training for those who have taken it already, and training to support children with special needs and their families.

Other administrative/skills-based training needs identified by community and regional respondents included: case management/assessment and screening; writing proposals; workshop facilitation; computer training; health promotion and planning; and community engagement and outreach. Training which can be passed on to community members (content-based training) included: FASD, nutrition, menu planning, breastfeeding, exercise, child safety, parenting and certified ECE training.

What training is being provided to community staff?

An internal scan of planned community level training between fiscal years 2005/06 and 2007/08[95] indicates the most common[96] 'administrative/individual skills-oriented training' was: outreach/home visiting, curriculum development, asset mapping, work planning, family violence, first aid, and

[94] The CY Training Review Draft Report, August 2009 - a total of 93 community staff questionnaires were completed: 59 in Manitoba, 18 in Quebec and 16 in Ontario and 7 phone interviews were completed with FNIH regional managers.

evaluation. The most common 'content-based training' was: FASD, special needs, parenting skills, nutrition, breastfeeding, doula training, early childhood education, mental health intervention, traditional teachings, and injury prevention.

Is the training offered aligned with identified needs – is it meeting the needs?

Based on information provided in the Training Review and in the CY Training Scan, training is aligned with identified needs. Most regions have regional advisory committees made up of community representatives who participate in the planning of training activities – this helps to ensure that community needs are reflected in regional training events.

However, challenges do exist. Community respondents identified the following issues: not enough funding to take advantage of training opportunities (65%); not enough staff to take time away from the office (40%); and, lack of training opportunities relevant to their position (27%). Some respondents indicated that they could only take free or low cost training because of the lack of funding.

Are community staff satisfied with the training provided?

Community respondents in the CY Training Review were clearly satisfied with the training they had received -- 82% of all question respondents rated past sessions above average to excellent. Eighteen percent of respondents rated past sessions below average to average and provided the following feedback about their rationale: training was not hands-on; just sitting and listening; outreach training should be facilitated by an outreach worker; training was not directed to them and did not apply to them and their communities; training went too fast; training was repeat information; training needed to supply more information; and, training had very little or no First Nation content.

How has training helped the community staff?

Seventy-eight percent of community respondents provided feedback on training and job satisfaction and 99% of those respondents said that their job satisfaction had increased: 28% of respondents said that they had gained knowledge through the training process; 22% of respondents mentioned that training had provided them with increased confidence and motivation; 17% of respondents indicated that training had provided them with skills to better do their jobs; 11.5% of respondents stated they were able to bring more information and resources back to their communities; and 10% said they were able to network and share information with workers from other First Nations. Seventy-six percent of respondents stated that the training "contributed to my professional development".

How have communities been impacted by training of community staff?

When asked how the training had made a difference for the respondent and their community, the majority (85%) answered, "I feel better able to support families". The second most common response (80%) was "I feel I am contributing to my First Nation community". A considerable amount of survey responses focused on the benefits to the children, their families and the community as a whole and the trained staff's ability to share the information that they had learned: 62% responded: "I feel we are able to offer different or specialized programs". Regional respondents also noted that the communities have benefited from this training including: more qualified and motivated program staff; stronger and more effective programs; and more variety in the program activities available.

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95 Internal CYD Training Scan 2005/06-2007/08

96 'most common' refers to the number of regions who offered this type of training

Does any of the training offer culturally specific, relevant information/resources?

Over three-quarters (83%) of the community respondents who answered the question on cultural relevance indicated that the training they had received was culturally relevant (63%), or somewhat culturally relevant (20%). 17% of respondents did not think the training they received was culturally relevant. (Nineteen percent of participants did not answer this question.) Regional respondents mentioned that information in the training was adapted to be more culturally relevant based on discussions with regional First Nation advisory groups and/or communities.

What partnerships have been developed to provide training? Were these ongoing or one time?

Results from the CY Training Review show that CY has developed relationships with a number of training partners, including: regional Aboriginal organizations; training institutes/colleges/universities; provincial/federal government ministries and departments; and, other training providers specialized in training childcare workers.

10.2.1.1. CONCLUSIONS FROM CY TRAINING REVIEW

Conclusion

Information provided in the CY Training Review indicates that training to support human resource capacity in CY's programs is well aligned with identified needs. The top two listed training needs demonstrated these two categories: Management Training (Supervisory Tips/Human Resource Management) and Working with Special Needs Children and their Families. Over three-quarters of community staff respondents were satisfied with the training they received and stated that training had increased their confidence, motivation, skills and/or overall job satisfaction. A majority stated that training was culturally relevant and that it had benefited the children and families in their communities.

It should also be noted that many of the community respondents stated that there was inadequate funding for training and that communication and planning on training could be improved.

Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

The information compiled from the CY Training Review suggests that children's program investments in training are contributing to increased human resource capacity.

10.3. Summary of Principal Findings on Ownership and Human Resources

Evaluation Questions	
E4a.	Does the grouping of the children's program investments contribute to increased First Nations ownership to deliver child health programs and supports?
E4b.	Does the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

SUMMARY OF PRINCIPAL FINDINGS FOR EVALUATION QUESTION (E4)

The key findings are:

- There is increased involvement of First Nations in decisions about the programs in the past 5 years in some communities.
- The CY Training Review found that training to support human resource capacity in CY programs is well-aligned with needs. Many of the community respondents interviewed stated that there was inadequate funding for training and that communication and planning on training could be improved.
- The CY Training Review found that children's program investments in training are contributing to increased human resource capacity.

Section 11. OTHER FINDINGS

This section includes information on two topics not within the scope of the evaluation, but for which FNIHB program staff sought additional information, namely, funding models and volunteer time. Findings are also presented on success targets.

Conclusions and recommendations on these two topics are not included within this report as they fall outside of the scope and terms of reference for the evaluation.

11.1. Funding Models

The scope for First Nations decision-making is constrained by the amount of funding available for the CY programs and the funding model applied in the various communities. Two-thirds of the FNIHB staff surveyed said that the funding model had an impact on the results of the CY programs.

FNIHB Staff were asked to rate the appropriateness of funding models [97] and if these have an impact on CY program results. Respondents were asked to identify two main factors that facilitate and impede the ability of First Nations to enter into flexible funding arrangements:

- 47% rated funding models as 'Very/Quite appropriate' and 47% said they were 'Somewhat' appropriate. Six percent said they were not appropriate at all.
- 48% said that the funding models have an impact on CY program results, 18% said they have some impact, and 4% said 'Not at all'. (30% said 'Don't know' and some said it was too soon to say with new arrangements.)

The factors identified by about half the FNIHB staff as facilitating the ability of First Nations to enter flexible transfer agreements were:

- Community capacity & staff with the ability to manage funding and trained staff to put the plan into action

[97] Funding models were defined as: (i) set; (ii) transitional; (iii) flexible; and (iv) flexible-transfer.

- Having community health plans developed and followed
- Leadership support with a strong government structure and band management

About half the FNIHB staff identified the lack of capacity, community health plans and leadership support as the main barriers limiting the ability of First Nations to enter these agreements. Other factors identified by FNIHB staff that may facilitate or impede entry into the agreements were: having strong cluster teams in the FNIHB regions to support communities and planning discussions between the communities and FNIHB regions, coordination of provincial health services, the size and location of communities, lack of guidelines, financial challenges, and third party management.

Overall, funding models were seen as appropriate by over 90% of FNIHB staff and as having an impact on the results of the CY programs by about two-thirds of FNIHB staff.

11.2. Volunteering in the Communities

The Participant Survey asked about the extent to which participants are involved in volunteer activities in their communities and found that:

- Nearly half of program participants (47.1%) said that they volunteer their time with 10.9% volunteering in the CY programs, 11.3% in other programs, 10.9% in community sporting or recreation events, and 27.6% in other community events; and
- About two third of people (67.5%) said they volunteer 1to 2 times a month, 21.7% volunteer 3 to 5 times a month, and 10.8% volunteering more than 5 times a month.
- These responses suggest that many participants in the CY programs are involved in volunteer activities within their communities on a regular basis.

11.3. Summary of Other Findings

- Overall, funding models were seen as appropriate by over 90% of FNIHB staff and as having an impact on the results of the CY programs by about two-thirds of FNIHB staff.
- Available information suggests that many participants in the CY programs are involved in volunteer activities within their communities on a regular basis.

Section 12. FINDINGS AND CONCLUSIONS

This section summarizes the findings for the relevance and effectiveness evaluation questions, and the conclusions based on these findings.

In interpreting the findings, it is important to note the following two factors that relate to the evaluation questions. First, as noted in Section 1 of this evaluation report, the purpose of the CY Cluster evaluation was to assess the relevance and effectiveness of the CY Cluster as a whole, and the evaluation was not

intended to evaluate the individual programs within the Cluster. Therefore, the findings and conclusions that follow refer to the CY Cluster as a group of programs and should not be interpreted as findings about the individual CY programs.

Secondly, as noted in Section 2 of this evaluation report, the coverage and reach of the CY Cluster varies among First Nations with only 33.9% of First Nations currently receiving some funding for all four of the CY programs. The total CY funding available is insufficient to allow funding for all the CY programs in all First Nations. The evaluation data includes a range of First Nations communities with varying numbers of CY programs and funding amounts. Furthermore, the funding available within any individual community may not be sufficient to meet all of the demands for services in that community.

Therefore, the findings and conclusions that follow are based on the effectiveness of the CY Cluster across the 37 First Nations sampled within existing funding limitations, and should not be interpreted as findings about the effectiveness of the cluster in any individual First Nation community.

12.1. Findings and Conclusions for Each Evaluation Question

The findings and conclusions are presented for each of the evaluation questions.

R1. Does the CY Cluster address clearly identified health needs of FN children and youth?

Current health needs of young First Nations children include a wide range of significant disparities or 'gaps' as compared with other Canadian children. The existing literature and FNIHB documents have identified some health needs (such as breastfeeding and smoking during pregnancy) but many others have not been measured due to lack of data. Perceived health needs vary by the age of the child, and include other concerns not identified in the literature. In-depth needs assessments are required as a basis for defining child health priorities in the CY Cluster and for community-based programming.

Trends in health needs over time indicate improvement on some health indicators, especially rates of breastfeeding, and declining infant mortality rates. At the aggregate level, a key trend is the growing volume of health needs related especially to the higher rate of population growth for First Nations as compared with the Canadian population. However, rates of growth vary among First Nations. Some types of health needs are increasing more rapidly, and newly emerging health needs were also identified. Additional information would be required to determine the extent of changes in the types of health needs and assess the relationship of these health needs to the CY Cluster activities.

There is a clear link *at a cluster level* between many of the key child health needs and CY program activities. However, there is insufficient funding to provide for all four CY Cluster programs in all First Nations, and CY programs and services available vary from community to community. Therefore, many First Nations have incomplete ranges of programs and services to address the key child health issues. As well, some of the key child health needs identified are not a major or minor focus of the CY Cluster, but may be addressed through other programs. FNIHB has some other programs or initiatives related to some of these issues such as the child injury, and there are non-FNIHB programs related to child care and early childhood development that cut across many of the same issues. Further research across a broader range of programs would be required to assess the extent to which non-CY Cluster programs and activities address child health and development needs, and to determine the extent of 'gaps' in programs to address the health needs.

The CY Cluster is moderately successful in addressing the health needs and more closely matched to some health needs than others. The CY Cluster at the overall cluster level appears to be least well-matched to health needs for healthy nutrition for children and of special needs children.

At the community level, the CY Cluster was rated as successful in meeting health needs by 35% of FNIHB staff and 70% of community staff, and some health needs in communities were better met by the CY Cluster than others. Prenatal care, preparing children for school, and dental health were most successful whereas First Nations languages, maternal mental wellness and, special needs were rated below average. Among people served by the CY Cluster, there is a high level of satisfaction with the services received.

Conclusion: At an overall Cluster level, the CY Cluster was found to address some clearly identified health needs of young First Nations children. However, the CY programs do not address all of these health needs because services are not all available in all communities. At the community level, some types of health needs in the communities are better addressed than others. These findings suggest that there are important health needs that are not being addressed including special needs, and further investigation of the CY and non-CY programs would be required to assess potential service 'gaps'.

R2. To what extent is this cluster linked to a government priority?

Since 2003, the overall rationale for the CY Cluster has related to the principles of investing 'upstream' to achieve improved health outcomes for First Nations and recognition of the importance of the early years in child development as a foundation for lifelong health and well-being.

Since the late 1990's, successive government decisions and Budgets have expanded policies and funding available to achieve two overall objectives: first, to provide services to First Nations children on-reserve that are available to other children living in similar geographic areas, and, secondly, to develop and enhance a continuum of services for child health and well-being from prenatal stages to age 5.

The CY Cluster (as an integrated groups of activities) specifically relates to the 2002 Federal Strategy on Early Childhood Development for First Nations and Other Aboriginal Children and its priority to work towards better integration of federal childhood development programs and services, and a government decision in 2005 for enhancing early learning and child care for First Nations children living on-reserve.

Conclusion: The CY Cluster is clearly linked to federal priorities to enhance the health and well-being of First Nations children living on-reserve, and is consistent with 1988 federal policy to transfer health services to First Nations control.

R3. To what extent is this cluster appropriate to the federal government and a core federal role?

The CY Cluster is appropriate to the federal government and a core federal role to address First Nations health. Individual program components and the CY Cluster are consistent with the goal of the Indian Health Policy and the federal roles in public health and health promotion. The federal government is continuing to implement the long-term plan to transfer delivery and administration of health care programs to First Nations control.

As part of FNIHB's Community Programs, the CY Cluster is administered so as to contribute to the overall mandate of FNIHB in assisting First Nations to address health barriers and attain health levels comparable to other Canadians, by building strong partnerships with First Nations to improve the health system. Development of the integrated CY Cluster since 2005 is consistent with longer terms trends toward increasing devolution of delivery responsibilities, and development of the Tripartite Agreements for First Nations health care delivery.

Conclusion: The CY Cluster is appropriate to the federal government and a core federal role as well as consistent with trends toward First Nations health care delivery.

E1. Is the grouping of the children's programs, be it 2, 3, or 4, meeting the individual health needs? If so, how?

CY programs and services have increased awareness and practice of healthy behaviours across a broad range of indicators, although areas for further improvement were identified. Further research would be required to quantify the capacity shortfalls to meet demand or to reach the intended target or eligible populations, to quantify the special needs problems and services required, and to investigate variations in awareness and practice of healthy behaviours among the various areas and for children at different ages.

Participation rates in CY programs have increased in the past 5 years. However, the capacity of programs in the communities to further increase participation rates appears to be limited. Access to CY programs has improved in some communities over the past five years making it easier for mothers and children to obtain the services they need. However, there are continuing barriers to access, and the lack of services for special needs was identified as a key concern by both FNIHB and community staff.

The CY Cluster is moderately effective in providing quality programs. The services are highly rated by the program participants responding to the evaluation surveys in the selected communities. The community delivery staff is experienced and many have qualifications related to the programs delivered, tend to work full-time in these programs, and the majority have several years of experience in these areas. At the same time, community staff face several challenges in providing the amounts and depths of services to meet the health needs, most notably related to the staffing levels which are associated with the funding available in local communities.

The CY programs and services have increased awareness across the broad range of indicators of healthy behaviours. Between one half and three-quarters of CY program participants surveyed said that they were much better informed as a result of the information they received. There were higher ratings on maternal prenatal care and breastfeeding than on child nutrition and development indicators.

Practice of healthy behaviours CY program participants has increased. The evaluation found that between one half and three-quarters of program participants surveyed said that they practice the healthy behaviours all or most of the time, and 65-85% of community staff surveyed also reported increased practice of these behaviours by the participants. The CY program participants surveyed reported that the CY program information had contributed to practice of healthy behaviours to a considerable extent.

The effects of the CY programs were more marked in areas of maternal health than in most areas of childhood development. In the case of breastfeeding, while initiation rates were high, it was not maintained for the first six months by the majority of mothers. Reading with children and use of First Nations languages were identified as areas for further improvement, and the major barrier to improving child nutrition was lack of adequate financial resources to cover the high cost of food.

Conclusions: The evaluation concluded that the CY Cluster is effective in meeting health needs of program participants by increasing participation, and moderately effective in providing quality programs given staffing levels for program delivery. Areas that could be strengthened include: access to services for children with special needs and their families, support and information about child nutrition, and the incorporation and promotion of FN languages and cultures in CY programming.

E2. Do the children's programs work together at the national, regional, community levels to meet expected logic model outcomes? If so, how?

There is a continuum of programs in the CY Cluster to address maternal and child health needs for age 0 to 6 at the cluster program level and in some communities. There is evidence from FNIHB and community staff as well as the participants surveyed that the continuum has improved in the past five years. However, there is insufficient funding to provide a continuum services in all communities and to address all the health needs in many communities.

The continuum of programs is enhanced by networking and collaboration at all levels of FNIHB and in the communities. All the evidence suggested that networking and collaboration are good and improving at all levels. There is considerable collaboration both among the four CY programs and between the CY and non-CY programs at the community level.

Conclusions: The CY Cluster provides an improved continuum of programs that is enhanced by considerable networking and collaboration at all levels. Some areas for further improvement were identified as were constraints to increasing collaboration.

E3. Are there any unintended positive or negative outcomes as a result of carrying out the CY Cluster?

Unintended Outcomes Identified Principally by FNIHB Staff

A range of positive and negative outcomes from the CY Cluster were identified. With the data available, it is not possible to determine if the outcomes identified are localized or can be generalized to different regions, other communities and/or to all CY programs.

Delivery of CY programs at the community level fosters integrated approaches to services planning and more effective delivery. Positive outcomes include improved community awareness of their health needs and assets, supports the cluster-based approach to children's programming. At the same time, these trends tend to highlight resource and funding limitations as well as service gaps and unmet health needs.

Participation in CY programs leads to a wide range of positive effects for parents and children that go beyond the focus on 'healthier behaviours' themselves. These relate to broader outcomes for parenting, social functioning, and the overall well-being of children and families that are not currently identified as part of the CY Cluster logic model.

CY programs are seen as fostering the inclusion of traditions and cultures into activities, and, and in some cases, to improve the reach of some services to women who may not have qualified for supports under previous programs. At the same time, interruptions of services (related to staff shortages or funding delays) have negative impacts on clients in need of support especially for those who may be 'in crisis' or have limited other resources to meet basic health needs.

Communities are strained to meet their health needs with existing resources. Despite dedicated staff and sharing of resources in many cases, it is challenging for communities to meet their health needs with the programs and funding available. Communities may not understand the basis for their funding allocations, and it was suggested that this can lead to tensions among communities.

Conclusions: The CY Cluster has both positive and negative outcomes that are not currently identified in the cluster logic model and have some implications for the CY Cluster as currently designed and delivered.

Unintended Outcomes Identified Principally by Community Staff

The principal findings on **positive** unintended outcomes are:

- Delivery of CY programs as a group at the community level is seen as fostering integrated approaches to services planning and more effective delivery.
- Participation in CY programs leads to a wide range of positive effects for parents and children that go beyond the focus on 'healthier behaviours' themselves.
- CY programs are seen as fostering the inclusion of traditions and cultures into activities, and, and in some cases, to have improved the reach of some services to women who may not have qualified for supports under previous programs.

The principal findings on **negative** unintended outcomes are:

- Community staff are concerned that the cluster-based approach will cause an increased demand for services that can not be met with current funding levels.
- Many communities, and more so smaller communities, need additional support on how to identify, prioritize and address health needs complete with suggestions and examples of how this might be done.
- FNIHB does not provide structured, integrated practices and guidance documentation to support communities planning for and delivering health needs services and support.
- Communities not funded for specific CY programs are not receiving information about those programs and thus are missing the opportunity to incorporate some of the elements into the other programs they are delivering.

Conclusions: The evaluation identified the need for additional support on how to identify, prioritize and address health needs through structured integrated practices and guidance documentation. Moreover, the evaluation noted that the CY logic model was not designed to capture outcomes related to parenting, social functioning, and the overall well-being of children and families.

E4a.1 Has FN community ownership to deliver maternal and child health programs and supports increased?

There has been increased involvement of First Nations in decisions about the programs in the past 5 years in some communities.

Conclusion: Increased involvement of First Nations in decisions about the CY programs can be expected to contribute to increased ownership of the programs and supports.

E4b. Do the grouping of the children's program investments contribute to increased human resource capacity (i.e., training) to deliver children and youth programs in FN communities?

The CY Training Review study found that:

- **Training** to support human resource capacity in CY's programs is well aligned with identified needs. Many of the community respondents stated that there was inadequate funding for training and that communication and planning on training could be improved.
- **Human resource capacity**: children's program investments in training are contributing to increased human resource capacity.

Conclusion: The CY Training Review concluded that training contributes to increased capacity to deliver youth programs.

12.2. Other Findings

Funding models

Overall, funding models were seen as appropriate by over 90% of FNIHB staff and as having an impact on the results of the CY programs by about two-thirds of FNIHB staff.

Conclusion: Funding models are seen as being appropriate.

Volunteering

Information available suggests that many participants in the CY programs are involved in volunteer activities within their communities on a regular basis.

No conclusions are presented.

Section 13. RECOMMENDATIONS

The CY Cluster has made considerable progress in enhancing the framework for a continuum of services to promote healthy child growth and development. The following recommendations, based upon the findings and conclusions from this evaluation study, are proposed with a view to the continuing development of measures to meet the health needs of First Nations children.

The recommendations presented here address themes, some of which include elements from more than one of the conclusions presented in the previous section.

13.1. Meeting the Health Needs of FN Cildren and Their Families

The evaluation concluded that, at an overall Cluster level, the CY Cluster addresses identified community health needs of young First Nations children and their families. Key health issues requiring additional focus by CYD include: the promotion of First Nations languages, support for maternal mental wellness, support and information about child nutrition and, services for children with special needs and their families.

The finding also demonstrated the need to monitor new and emerging trends to ensure that programming remains relevant key gaps are identified.

Recommendation #1:

- That Health Canada monitor new and emerging health needs for First Nations and Inuit children and their families, including:
  - children with special needs and their families;
  - maternal mental wellness;

- Healthy nutrition; and
- First Nations languages and culture.

13.2. Collaboration and Networking

While the scope of this evaluation was limited to the CY Cluster, it was recognized that other initiatives and programs funded by FNIHB and other federal government departments provide related services that contribute towards improved maternal and child health.

At the community level, the evaluation indicates that many communities are ahead of FNIHB in that they initiated their cluster-based approach prior to FNIHB. However, their cluster based approach is for health and wellness as a whole, and is not limited to the CY Cluster.

These communities deliver their health and wellness programs and projects using a community-based cluster approach. This community-based cluster approach includes CYD programs, programs funded by other divisions within FNIHB, and programs funded by other government departments and ministries.

Recommendation #2:

- To effectively describe the continuum of programs, provide meaningful information on program outputs and outcomes and to support future evaluation and reporting, FNIHB needs to:
  - Assess the relationship with other program areas;
  - Review the reporting requirements and standardize the program activity reporting;
  - Identify gaps in programming; and
  - Identify where increased coordination would improve health outcomes.

13.3. Program Planning and Reporting

Assessing the results of CY Cluster's activities and expenditures proved challenging because of the lack of complete and accurate CY program data produced using common definitions for the gathering and reporting of the data. In particular, no data could be obtained on basic measures such as the numbers of program participants served, and the services provided in the various CY programs at national, regional and community levels. The lack of consistent basic information on the numbers of people served and the units of service provided, prevented the assessment of the results of the CY Cluster in meeting children's health needs.

Recommendations #3 and #4:

- Resources and guides should be developed and/or updated to provide communities with the tools to identify and prioritize and address health needs.
- The CY Cluster Logic Model should be updated to clearly identify the outcomes for children and families.

13.4. CY Training and Capacity Building

The Training review concluded that overall training to support human resource capacity in CY programs is well aligned with identified needs however, communication and planning on training could be improved.

Recommendations #5 and #6:

- A training and capacity building strategy should be developed to address issues such as: planning and communication, tool development, development of culturally appropriate, standardized and accredited training with innovative delivery options (e-learning and distance education); and recruitment and retention issues.
- Tools to monitor the effectiveness and impact of training on workers and communities, as well as mechanisms to share best practices, should be developed.

Appendix 1. GLOSSARY OF TERMS

This appendix presents and explains the terms not commonly used on a daily basis, or which have meanings that are somewhat different from common usage. Many of the explanations were obtained from the document entitled *FNIHB Contribution Funding Framework: Overview.*

Acronyms are presented Section 1.7 of this report.

Cluster: A group of programs, services and/or activities that share common objectives and expected outcomes.

Collaboration: The process by which FNIHB works together with key stakeholders including NAHO (National Aboriginal Health Organization), AFN (Assembly of First Nations), and other F/P/T partners, involving them in decision-making in the design, development, and/or implementation of programs to take account of Aboriginal perspectives.

Continuum: A coordinated network of services and supports to meet the multiple and changing health needs of children from pre-natal to age 6.

Contribution Agreement (CA): A Contribution Agreement is a formal agreement with a First Nation or First Nations organization that specifies the funding and reporting arrangements for programs or services to be provided.

Coverage: The percentage of First Nations that are receiving funding and/or providing CY programs and services in their communities.

Disparities: The gaps in health outcomes for First Nations children as compared with other Canadian children.

Effectiveness: How well programs are meeting the defined health needs.

Eligible Population: The population that meets the criteria for receiving services under the programs.

Evaluation Issues: The broad topics defined by FNIHB for the scope of the CY Cluster Evaluation, namely, the relevance and effectiveness of the CY Cluster.

Evaluation Questions: The specific questions defined by FNIHB to be addressed in the CY Cluster Evaluation.

Evaluation Sub-questions: The detailed sub-questions defined by FNIHB to be addressed in the CY Cluster Evaluation.

Funding Models:

- **Set Funding:** In the Set Funding Model, resources are to be used as indicated in the agreement. However, should it be necessary, funds can be reallocated among activities within individual program components with written approval of the Minister.
- **Transitional Funding:** In the Transitional Funding Model, resources are to be used as indicated in the agreement. However, should it be necessary, funds can be reallocated among program components within an individual authority as long as mandatory programs are delivered. The Multi-Year Work Plan must be updated to reflect the changes. The Recipient may, with the approval of the Minister, carry forward program funding with the obligation to reinvest the funding in the following fiscal year within the same program authority.

- **Flexible Funding:** In the Flexible Funding Model, the Recipient must deliver all programs including mandatory programs, and has the ability to design or integrate new programs and direct resources according to their health priorities. The Recipient is allowed to retain surpluses for reinvestment in approved health priorities (exemption from section 7.12.1 of the Treasury Board Policy on Transfer Payments), and is responsible for any deficits incurred. A comprehensive Health Plan must be provided to serve as a basis for reporting.

- **Flexible Transfer Funding:** In the Flexible Transfer Funding Model, the Recipient may design or integrate new programs and direct resources according to their health priorities, as long as mandatory programs are delivered. Non-mandatory programs can be redesigned. Recipients under this model are not required to report on all indicators listed in the Reporting Strategy. Instead, they report annually to their members and the Minister of Health on the indicators they have selected in their Health Plan for demonstrating achievement toward results. This model allows recipients to retain surpluses and be responsible for any deficits incurred in delivering programs (exemption from section 7.12.1 of the Treasury Board Policy on Transfer Payments). A comprehensive Health Plan must be provided to serve as a basis for reporting.

Health Needs: The conditions necessary for healthy child growth and development as measured by outcome indicators of child health and well-being.

Health Needs Disparities of First Nations Children as the health disparities (gaps) between First Nations and other children in Canada.

Health Plan: A comprehensive plan developed by the Recipient and approved by the Minister that addresses the Recipient's plan to design, manage, and deliver health programs according to community health needs and priorities.

Mandatory Programs: Those programs that are identified as obligatory to ensure public health and safety (i.e., communicable disease control, environmental health, and treatment services).

Memorandum of Understanding (MOU): A Memorandum of Understanding is a formal agreement between First Nations and other organizations that specifies the terms of collaborations or coordination of services to be provided by parties to the agreement.

Multi-Year Work Plan: A multi-year plan that reflects the health priorities of the Recipient and includes the goals, objectives, activities and outcome measures for each program area, as well as how resources will be allocated in meeting those priorities.

Networking: The sharing of information among individuals, groups and institutions that may involve both formal processes as well as informal working relationships.

Performance Indicators: Measures of the outputs and/or outcomes of program activities in relation to the stated program objectives.

Reach: The proportion of an eligible population that receives services under the programs.

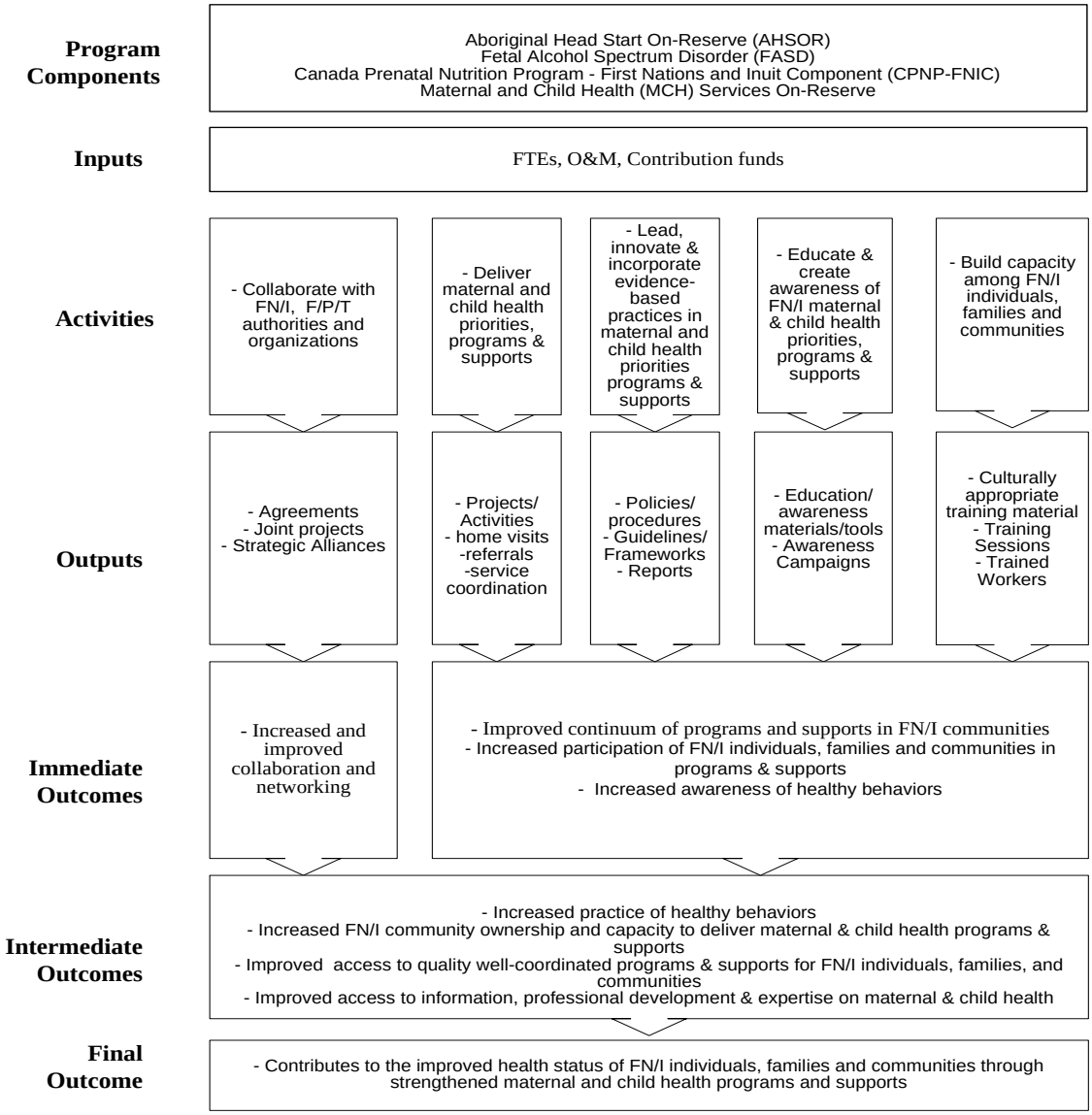
Recipient: A party who has entered into a funding arrangement to receive funding from the First Nations and Inuit Health Branch for the delivery of health programs and services

Relevance: The need for government programs.

Surplus: Any funding left over after a recipient delivers the range of health programs or services as per the term and conditions of their contribution agreement.

Appendix 2. LOGIC MODEL FOR THE CY CLUSTER

CHILDREN AND YOUTH LOGIC MODEL



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Appendix 4. SELECTION CRITERIA FOR THE COMMUNITY VISITS

Four criteria were agreed upon for the selection of the communities:

- Criteria #1: *The community is not in a state of crisis. This can include a range of factors beginning with being in third party management through to social or other problems that would make the community a poor choice for a site visit.* Communities that were identified as being in a *state of crisis* were not selected.

- Criteria #2: Continuity. *The community project team has representatives who have been in place since the start of their project so that there is a good source(s) of knowledge and project history.* Communities that were identified as lacking continuity were not selected as there is concern as to the availability of useful information within the community.

- Criteria #3: Cluster. *Identify communities that are part of a cluster project.* Only one community per cluster will be visited during the site visits.

- Criteria #4: *The project has been operational on or before 1 April 2007 . . . This means that there is at least one MCH client case record dated on or before 1 April 2007.* Only projects started on or before 1 April 2007 will be visited during the site visits.

This evaluation was designed to collect survey data from participants and program delivery staff in 34 First Nations. In the end information was received from 37 communities. The planned coverage of 34 First Nations was defined in the original RFP issued by Health Canada (2008), as were the sampling criteria. The intention was to include a range of sizes and locations of First Nations across Canada, as well as to include examples of communities with different mixes of the four CY Cluster programs.

The final selection of 34 communities was to be made based on these overall criteria as well as including additional substitute communities in case some of the initial 34 were not able to participate. The first change in the selection of the site-visit communities came about as a result of the decision to not visit communities in northern Ontario and Manitoba because of the outbreak in the H1N1 virus in many of those communities.

The second change in site selection came in Saskatchewan where it was decided that site-visits were to be coordinated through the Tribal Councils, as the Tribal Councils were the project holders and the communities were tasked to deliver the CY programs within their communities. The site-visits in Saskatchewan were conducted at two Tribal Councils, and the 18 communities they represent were invited to attend. Participant questionnaires and community staff questionnaires were distributed to all 18 communities represented by the Tribal Councils.

In the end, information was received from 37 communities; of which 13 were within the two Tribal Councils, and 24 were communities that managed their CY programs without tribal council support.

The final selection of the 34 communities includes a range of community sizes, locations, and service patterns. Therefore, there can be some confidence that this selection covers a diversity of First Nations across Canada, even though it is not statistically representative of all First Nation communities.

Program participants in the 37 communities for the group sessions were selected by community staff. Information collected in the 37 site visits was based on structured workbooks and questions rather than an ‘open’ discussion group or ‘sharing circle’ method. The structured approach was selected in order to gather information on the effectiveness of the CY Cluster in improving awareness and practice of healthy

behaviours. While the majority of CY community staff in the 37 site visit communities had the opportunity to complete the Community Staff Survey, 'selection' of program participants was based on purposeful sampling.

Community staff enlisted program participants to attend the sessions where the workbooks were to be completed in a group setting. Potential literacy and language issues were resolved by having participants complete the workbooks in group sessions where assistance could be provided. To include mothers in the workforce (who would not be available during the day), other program participants could complete the workbooks on their own, and return them to the evaluators by mail.

This method of selecting participants does not provide a reliable, statistically-representative sample from which to generalize to all CY program participants in Canada. However, since there is no universal list of participants in CY Cluster programs, it would be impossible to construct a statistically-representative sample of participants. This survey method includes a common issue with opinion-type surveys, namely, respondent 'recall', although it avoids other issues such as non-response bias and interpreting data with low survey response rates.