Evaluation of the Healthy Child Development Program

Final Report

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Indigenous Services Canada
Services aux Autochtones Canada
Canada

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List of Acronyms

AHSOR	Aboriginal Head Start on Reserve
CBRT	Community-Based Reporting Template
CPNP	Canada Prenatal Nutrition Program
FASD	Fetal Alcohol Spectrum Disorder
FNIGC	First Nations Information Governance Centre
FNIHB	First Nations and Inuit Health Branch
FNREES	First Nations Regional Early Childhood, Education, and Employment Survey
HCD	Healthy Child Development
ISC	Indigenous Services Canada
MCH	Maternal Child Health
NFR	New Fiscal Relationship (grant)
RHS	Regional Health Survey
TB	Treasury Board

Executive Summary

Background

The First Nations and Inuit Health Branch (FNIHB) within ISC funds a suite of HCD programs and services, which are delivered by communities and aim to improve overall health outcomes for First Nations on reserve and Inuit in maternal, infant, child, and family health. The primary activities across the programs include improving nutrition; promoting early literacy and learning; encouraging physical activities; promoting healthy relationships as well as emotional and mental health; promoting injury prevention and harm reduction; and promoting First Nations and Inuit culture. Brief descriptions of the sub-program areas within HCD are provided below:

- Maternal Child Health (MCH) program: The primary goal of the MCH program is to promote healthy pregnancies and support families with infants and children. The program includes components related to: case management; screening, assessment and referrals; and, health promotion strategies to improve maternal child health and identify risk factors for gestational diabetes, substance use, maternal and infant mental health issues, developmental delays, and family violence. Communities determine what aspects of the program they will deliver based on their unique needs and resources available.
- Fetal Alcohol Spectrum Disorder (FASD) program: The FASD program involves a combination of mentorship, community coordinators, and capacity building activities. Mentorship through home visitors provide support and trusting relationships with women at risk of drinking while pregnant; community coordinators work as case managers for children with FASD (e.g., access to diagnosis and services); and, capacity building activities may involve education, awareness raising, training, and asset mapping.
- Canada Prenatal Nutrition Program (CPNP): The CPNP aims to increase access to nutrition and lifestyle counselling, information, services, and resources to First Nations and Inuit women. Activities may include breastfeeding education and support, knowledge and skill building opportunities, and referrals to other services.
- Aboriginal Head Start on-Reserve (AHSOR) program: AHSOR funds activities that support the learning and developmental needs of young children 0-6 and their families living in First Nations communities, focusing on six core elements. The goal is to support early child development strategies that are designed and controlled by First Nations communities.

Evaluation Scope and Methodology

The overall purpose of the evaluation is to examine the Healthy Child Development (HCD) group of programs, as outlined in the five-year Evaluation Plan at Indigenous Services Canada and in accordance with the Treasury Board *Policy on Results.* The evaluation covers the period from Fiscal Year 2013-14 to 2018-19 to provide a neutral, evidence-based assessment of the relevance, effectiveness, and efficiency of the HCD programs. Additionally, the evaluation explored the following factors as they influence HCD programming: COVID-19, climate change, and service transfer. The evaluation focused on First Nations communities only, in line with a request from Inuit Tapiriit Kanatami for a separate, distinctions-based evaluation, to be conducted at a later date. All provinces and territories were included in the evaluation, except for British Columbia.

The evaluation relied on a mixed-methods approach: a document and literature review; 23 key informant interviews with ISC-FNIHB national and regional office staff; 11 in-person visits to communities delivering programs funded through HCD and 8 corresponding focus groups or individual discussions with community representatives;[1] 2 written submissions from First Nations representatives; and an online survey of 153 individuals working in/with First Nations communities.

Main Findings

Relevance

The evaluation found that the HCD program remains relevant as there is an ongoing need to support and invest in the well-being of First Nations children and families through early childhood programming to help close the gap in health outcomes and support a strong foundation for well-being across the life course. First Nations communities and the broader literature highlight experiences of ongoing health and social inequities among children and families – including, higher rates of nutrition and food insecurity, chronic disease, and poorer birth outcomes. Almost all (89%) community representatives surveyed reported that there is a continued need for programming, and that needs appear to have risen in acuteness and complexity (i.e., in the context of COVID-19, inflationary pressures, drug-related emergencies, more prevalent developmental delays, and grief and trauma).

The program also aligns with broader departmental mandates for supporting healthy individuals and communities, improving access to high-quality services, reducing inequities in health outcomes, and advancing the control over the delivery of programs and services. HCD also directly supports the Calls to Action from the Truth and Reconciliation Commission (i.e., Call #5, 12, 19, and 33).

Furthermore, the evaluation found that HCD programs are not duplicating other programs/services on reserve as they uniquely support the delivery of community-based programming focused on pregnancy, maternal health, and early child development (i.e., as it relates to other funding opportunities). To address limitations in HCD funding, communities may leverage other complementary funding sources, federal and provincial, to support specific areas of need (e.g., infrastructure, culture-based activity funding) where possible. Furthermore, communities indicated that HCD also works in collaboration with other programs such as Jordan's Principle and the First Nations and Inuit Child Care Initiative to holistically meet needs.

Effectiveness

The Healthy Child Development programs are contributing to the achievement of positive outcomes for children, women, and families. On an individual level, the programs are increasing knowledge and skill-building opportunities for new and expectant parents (e.g., baby food making, cooking skills, infant safety and development, parenting skills); improving access to essential needs (e.g., grocery vouchers, food hampers, transportation support, infant supplies); building resilience and a positive cultural identity; and revitalizing and connecting families with culture-based practices and traditions. More broadly, the programs are also contributing to the development of relationships and networks between children, caregivers, families, staff, and organizations. With increased investment in some of the program areas through Budget 2017,

[1] Site visits were planned, to the extent possible, to reflect a range of delivery contexts (e.g., region, geography/remoteness, population size, facilities, programs available).

this has supported improvement in program access and quality – however, as this was near the end of the evaluation timeframe, a fulsome understanding of impacts is not yet known.

Both ISC and community-based respondents spoke to the complementarity and collaboration occurring across HCD programs and beyond. For instance, community-based staff may hold multiple roles across programs (e.g., one staff may be both a MCH and FASD home visitor) and/or collaborate with other staff to deliver activities in conjunction. In particular, the CPNP, FASD, and MCH programs were frequently reported to be delivered as a combined program due to their close alignment in scope and mandate. Efforts to collaborate across program areas have several advantages, including enabling more holistic service delivery and creating a circle of care where children and families are brought into a broader network of supports. With respect to communication and collaboration between ISC and communities, several community representatives expressed an interest in more direct communication and engagement with regional ISC staff, including through information and resource sharing, providing technical support, and meeting with representatives through in-person visits to communities.

While communities engaged in the evaluation showcased innovative and community-driven activities and services, the evaluation found that an overall challenge limiting program impact is ongoing lack of access to the social determinants of health and well-being experienced among many First Nations children, families, and communities – such as food and nutrition, adequate housing and community infrastructure, and employment. As a result, program funding may be primarily aimed at meeting basic and immediate needs among children and families. Other barriers to impact as reported by community-based representatives include rising costs and population pressures against stagnant funding, an inability to recruit and retain a qualified workforce, a lack of capacity to respond to more specialized/acute needs among children and families, and an absence of adequate facilities to deliver programming. Among opportunities to increase program impact, a desire for greater knowledge sharing opportunities (e.g., to debrief, highlight promising practices and lessons learned) was identified across communities.

Two primary service gaps were identified through the evaluation: lack of universal access to programming, and gaps in youth-based services. Key informants and reports from partners identified the lack of universal access to the HCD programs in all First Nations communities as a critical service gap. As a result, not all First Nations children and families have equal access to services that are widely considered essential for promoting healthy development, preventing poor outcomes, and intervening during critical years to support a positive trajectory. Additionally, there was a reported gap in access to prevention-based programming for children above age 6. This may be due to a combination of factors including the entrenchment of historical program parameters (i.e., limiting services to birth to age 6) and knowledge gaps related to updates to the program's terms and conditions, and deficiencies in funding, which limit the ability of communities to offer expanded programming.

Efficiency

Following the previous evaluation recommendations, ISC-FNIHB has undertaken various measures to improve program performance, such as the initiation of partnership structures in all regions; producing program frameworks; developing an updated costing model; updating program standards; and revising program performance measures. However, some gaps remain. In particular, lack of universal access to the programs and ongoing funding gaps are a continued area of need. Additionally, key informants noted that the program's performance measurement strategy continues to encounter challenges to demonstrating impact. As self-determined service delivery and streamlined reporting remain a priority, continued consideration

for a reporting approach which informs program efficacy and aligns with First Nations priorities for data collection and indicators is needed.

Internally, management structures, human resources, and financial systems are appropriate to achieving results. Through FNIHB's focus on regionalization, ISC regional offices have a wide range of management structures and operational approaches that align with local priorities and functions. Frequently citing the departmental mandate for the transfer of services, ISC staff generally did not perceive a need for additional human resources to support operations. However, as communities are entering more flexible agreements and increasing control over services, some consideration for regional staff capacity to provide technical and administrative support to communities (e.g., transition planning, program development) were raised.

Above all, the most consistently reported challenge from community representatives and ISC national and regional staff is funding insufficiency, which has a corresponding impact on community capacity to deliver effective programming, reach all intended populations, recruit and retain qualified staff, and engage in long-term planning. To illustrate, less than 30% of survey respondents agreed or strongly agreed that the sufficiency, flexibility, and timeliness of HCD funding is adequate. While communities are undertaking all efforts to maximize program funding, it was consistently noted that additional funding is needed to realize program impact.

Sub-Program Findings

Aboriginal Head Start on-Reserve

The evaluation found that AHSOR programs are operating with a holistic approach to supporting child development – including integration of Nation-based culture and language activities, play-based learning, health promotion, nutritious food access, and involvement of parents and Elders. The key accomplishments within the AHSOR program as described by community representatives include strengthened connection to culture and positive identity, improved school readiness, the development of trusting relationships with children and families, and achievement of emotional and developmental milestones. The positive impacts of AHSOR programming have also been reported through the Regional Health Survey (RHS) and the First Nations Regional Early Childhood, Education, and Employment Survey (FNREEES).

While AHSOR programs have demonstrably contributed to positive outcomes for children and families, several challenges to effective program delivery were also noted. Frequently, survey and community-based respondents reported infrastructure and facility concerns due to lack of space, inadequate or unsafe outdoor access, outdated facilities, and overdue repairs and renovations. Additionally, funding has not increased or kept pace with population growth and changing needs/priorities.

Maternal Child Health Program

The MCH program functions as an important link between women, families, and the broader network of supports and services. MCH workers are often collaborating with other programs/staff (e.g., FASD, CPNP, dietitian, community nurse, and other services) to support families and children through a circle of care. However, growing/more complex needs within community, in conjunction with population growth and limited funding, appear to overwhelm the capacity of the program. With additional resources, community-based representatives described an interest in accessing culturally relevant training to deliver education and awareness on traditional childbirth and parenting practices. Furthermore, some indicated that updated home visitor safety training was needed to support clients with complex substance use.

Fetal Alcohol Spectrum Disorder Program

Due to limited funding, communities often reported "delivering" the FASD program through one-off events (e.g., awareness day, health fair) with a primary focus on education and awareness. According to the survey and community site visits, FASD appears to be most successful in building trusting relationships with people at risk of drinking while pregnant; representatives were in less agreement that the program is building capacity to manage address and prevent FASD, or supporting case management. In particular, case management and limited access to diagnostic services were reported as a barrier to effectively meeting the needs of those with FASD and/or people who are at risk of drinking while pregnant. An additional factor impacting program delivery as noted by ISC staff and community representatives is the ongoing stigma surrounding FASD and disclosure of alcohol use. In particular, a parent may avoid accessing services/supports due to fear of involvement of child welfare services. Accordingly, communities reported using strategies such as renaming the program to be more strengths-based (e.g., "wellness" program) and focusing on resilience and goal setting.

Canada Prenatal Nutrition Program

Staff delivering the CPNP reported activities such as prenatal classes, breastfeeding support groups, cooking education, infant food preparation, and providing food vouchers. Community-based representatives indicated that CPNP is most successful in increasing access to nutrition and lifestyle counselling and improving the diet of prenatal and breastfeeding First Nations women.

A primary challenge reported by regional staff, community engagements, and survey respondents is the rising cost of food prices and lack of increase in programming investments, which has greatly limited the scope of programming. As a result, one staff member may be responsible for CPNP alongside several other programs/services. Rising costs have also impacted communities overall, leading to higher rates of food security and increased demand on the program.

Wise Practices

The rich diversity across First Nations ways of knowing and being, cultural and traditional practices, histories, and geographic and economic contexts reiterates: 1) the lack of a single "best practice" in delivering programs, 2) the relevance of First Nations control over the design and implementation of HCD. The evaluation gathered general principles and practices as highlighted by community-based representatives, including regular consultation with community members to design programming in-line with priorities; offering land-based education and activities; collaborating with other program partners (e.g., across MCH, FASD, CPNP) to pool resources and offer more comprehensive interventions; grounding programming in culture, language, First Nations identity, and worldviews; offering group-based activities; and involving Elders in programming.

Climate Change

Generally, respondents did not indicate that climate change had directly or significantly impacted programming. To illustrate, approximately half of survey respondents (54%) reported feeling neutral about the impacts of climate change on program delivery, 17% strongly agreed or agreed that climate change had impacted the HCD programs, and 25% disagreed or strongly disagreed (n=153 overall).

With that being said, the impacts of climate change are particularly impacting rural and remote/isolated communities in areas such as: reduced windows for material and supply access

due to shortened ice road seasons, interruptions to land-based learning due to air quality advisories and extreme heat, disruptions to animal migration patterns and reduced access to traditional foods, and inadequate infrastructure to withstand extreme weather events.

Service Transfer
Respondents from ISC and on a community level noted that some progress has been made in supporting the return of control over services, as indicated by a gradual and overall trend in communities moving to more flexible arrangements and the development of partnership tables and co-management structures to foster First Nations decision making.

A review of the broader literature and qualitative discussions outlined several areas of opportunity to further advance service transfer. Notably, access to workforce development, training and mentorship, appropriate transition planning alongside ISC, and access to administrative and technical supports are among factors which can increase readiness and capacity for the transfer of control. Additionally, access to sufficient, long-term funding is a critical component to support planning, capacity building, and recruit and retain qualified staff.

COVID-19 Impacts
The evaluation found that the COVID-19 pandemic had a considerable impact on the HCD programs and, in many cases, has exacerbated needs in community. With respect to the delivery of programs, regional staff and communities reported that programs were not operational or were greatly limited in scope due to a variety of factors, including public health restrictions, redeployment of staff to address other priorities (e.g., safety, vaccinations, screening), staffing challenges (e.g., burnout and retention), and poor technology and connectivity infrastructure. Where possible, several communities reported pivoting to virtual services, which proved to be a promising practice to service delivery. The COVID-19 pandemic, ultimately, reiterated the importance of supporting Nations to exercise control over programming and services to best meet their needs and priorities.

Additionally, the evaluation found that the COVID-19 pandemic has had a ripple effect on the well-being of communities. Many community-based staff, survey respondents, and regional staff spoke to new/emerging challenges as a result of stress, isolation, grief and loss, and economic precarity. The implications of the pandemic for children, in particular, was highlighted as a significant area of concern to staff and one which requires greater resources to effectively address going forward.

Recommendations

Based on the findings of this evaluation report, it is recommended that ISC:

1. Identify mechanisms to improve program access, including through improved understanding of program needs, and identification of partnership opportunities and other mechanisms for increased and sustained program resources.

2. Identify concrete opportunities and mechanisms to support knowledge sharing across the HCD workforce and within sub-program areas to foster capacity building and facilitate diffusion of wise practices and lessons learned.

3. Regionally, increase partnership and relationship building efforts with communities (among those who desire) through regular communication, information sharing, and relationship building to support effective program delivery, co-identify solutions/opportunities, and build community capacity.

4. Alongside First Nations partners, explore opportunities to revise and innovate performance measurement approaches, built upon appropriate data sources, to improve assessment of program impact, and which aligns with First Nations approaches, while maintaining a focus on reduced reporting burden.

Management Response and Action Plan

Project Title: Evaluation of the Healthy Child Development Program

Management Response

Indigenous Services Canada, First Nations and Inuit Health Branch (ISC-FNIHB) acknowledges and concurs with the recommendations outlined in the report of the evaluation of the Healthy Child Development Program conducted by Indigenous Services Canada's Evaluation Directorate.

For all recommendations, ISC-FNIHB recognizes the importance of committed and dedicated action towards self-determination of Indigenous Peoples and towards service transfer. ISC-FNIHB is supporting First Nations to influence, manage and increase control over health programs and services that affect them and improve access to quality health services. While supporting these shifts, ISC-FNIHB continues to work with First Nations partners and communities in advancing their priorities, for example, supporting training and capacity building efforts in regions, and facilitating access or linkages to Healthy Child Development services, supports and resources. ISC-FNIHB recognises that the diversity across First Nations ways of knowing and being, cultural and traditional practices, and geographic and economic practices means there is a lack of a single "best practice" in delivery programs, and that First Nations control over the design and implementation of HCD programming is essential.

We will work with partners to examine options for sustainability of funding, incorporating traditional practices and knowledge transfer of best practices. ISC-FNIHB is committed to actively participating in discussions with First Nations partners, including the Assembly of First Nations, to determine where we go from here as a collective to address these issues.

ISC-FNIHB recognizes that challenges exist in illustrating the performance of HCD programming with the limited availability of program impact data, due to persistent data gaps in the existing performance management approaches used within the department. Addressing data challenges is a cross-cutting, interconnected issue and is a priority of the whole department. Therefore, although ISC-FNIHB agrees with Recommendation 4, we wish to emphasize that an individual program only holds some of the levers towards implementing this recommendation, and that we look forward to leveraging more department-wide efforts to further address the program's data needs. It is also worthwhile to note that some aspects of the recommendation have already been implemented. Since the completion of this evaluation, a number of changes with regards to reporting have been made or are underway. For fiscal year 2024-2025, based on calls from communities and the Assembly of First Nations, the Community Based Reporting Template (CBRT) has been eliminated as a departmental Data Collection Instrument (DCI). Instead, the Healthy Child Development program will have a stand-alone, program specific DCI, reflected in the 2024-2025 ISC Reporting Guide and the Grants and Contributions Information System (GCIMS). Additionally, as part of

the IELCC Transformation initiative, ISC-FNIHB is participating in work in collaboration with the Assembly of First Nations, Employment and Social Development Canada, and other Government departments to co-develop an Indigenous Early Learning and Child Care Results Framework, a process which will complement and inform our efforts to explore opportunities to revise and innovate performance measurement approaches within the program to improve assessment of program impact.

It is important to note that this evaluation covers the period from Fiscal Year 2013-14 to 2018-19. Data collection occurred well after this period, and after the height of the COVID-19 pandemic, when many Healthy Childhood Development programs and services were reduced or paused, and funding recipients/communities diverted resources to help address critical pandemic-related needs. Additionally, in 2017 the Government of Canada commenced significant investments in IELCC programming and infrastructure, which will improve program access through sustained investments, the impacts of which will be captured in the next evaluation.

The evaluation report identifies several cross-cutting topics such as service transfer and performance measurement, which implicate not only the Healthy Child Development Program but the Department as a whole. With this in mind, the Action Plan is focused on collaboration with First Nations partners, ISC sectors and other federal departments.

ISC-FNIHB intends to initiate implementation of the recommendations immediately. An annual review of the Management Response and Action Plan will be conducted by ISC Evaluation and shared with the ISC Performance Management and Evaluation Committee (PMEC) to monitor progress and activities.

Assurance
The Action Plan presents appropriate and realistic measures to address the evaluation’s recommendations, as well as timelines for initiating and completing the actions.

Action Plan Matrix

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
1. Identify mechanisms to improve program access, including through improved understanding of program needs, and identification of partnership opportunities and other mechanisms for increased and sustained program resources.	We **do** concur. To support this recommendation, the Healthy Child Development Program will: **Action 1.1**: Determine whether the Assembly of First Nations or other First Nations partners are interested in meeting to discuss priorities and needs as they relate to healthy child development in communities. (Q1 2024-2025) **Action 1.2**: Meet with the Assembly of First Nations or other interested First Nations partners to discuss said priorities (Q2-Q3, 2024-2025) **Action 1.3** Following actions 1.1 and 1.2, have discussions with regional officials, other ISC sectors (e.g. Education) and other federal government departments (e.g. ESDC, PHAC) to explore opportunities for increased support for Healthy Child Development Programs and services. (Q2-Q3, 2024-2025) **Action 1.4:** Building on the results of 1.1 – 1.3, work with the Chief Data Officer to improve forecasting of program demand, to inform mechanisms for seeking additional funding and for managing existing funding more efficiently, to better support community capacity to deliver Healthy Child Development services. (Q3-Q4, 2024-2025) **Action 1.5:** Develop and report on potential mechanisms for increased flexible and sustainable funding.(Q3-Q4, 2024-2025)	Director General responsible for Healthy Children, Youth, and Families, First Nations and Inuit Health Branch (FNIHB), Indigenous Services Canada (ISC)	*Start Date:* *April 2024* *Completion:* *March 31, 2025* *1.1 June 2024* *1.2 December 2024* *1.3 December 2024* *1.4 March 2025* *1.5 March 2025*	**Status:** ☐ Fully Implemented ☐ Partially Implemented ☐ Implementation did not Commence ☐ Obsolete **Update/Rationale:** **As of:** *(Insert Update Here)*
2. Identify concrete opportunities and mechanisms to support knowledge sharing across the HCD workforce and within sub-program areas to foster capacity building and facilitate diffusion of wise practices and lessons learned.	**Action 2.1:** ISC-FNIHB HQ and Regional Staff to meet virtually to discuss and identify mechanisms to support regular communication and knowledge sharing. (Q1, 2024-2025) **Action 2.2** Select and implement opportunities and mechanisms outlined in Action 2.1. (Q3-Q4, 2024-2025).	Director General responsible for Healthy Children, Youth, and Families, First Nations and Inuit Health Branch (FNIHB), Indigenous	*Start Date:* *April 2024* *Completion:* *March 2026* *2.1 June 2024* *2.2 March 2025* *2.3 March 2026*	**Status:** ☐ Fully Implemented ☐ Partially Implemented ☐ Implementation did not Commence ☐ Obsolete **Update/Rationale:** **As of:** *(Insert Update Here)*

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
	Action 2.3 Report on the effectiveness of the selected mechanisms after one year. (Q3-Q4, 2025-2026).	Services Canada (ISC)		
3. Regionally, increase partnership and relationship building efforts with communities (among those who desire) through regular communication, information sharing, and relationship building to support effective program delivery, co-identify solutions/opportunities, and build community capacity.	We **do** concur. ISC-FNIHB recognizes the importance of partnerships and relationships in effective program delivery, and acknowledges the evaluation evidence (i.e. finding 8) that suggests that some communities are seeking stronger relationships with ISC. While acknowledging the good working relationships that already exist between ISC and communities in many cases, it should also be noted that there is always room for improvement and further relationship-building efforts have already taken place since the end of the evaluated period. Additionally, the desire and capacity of communities to engage with regions may vary by region, and it is difficult to identify actions that can be implemented across all regions given this diversity. This diversity also creates challenges with respect to establishing a straightforward baseline measure of the quality of regions' relationships with communities and tracking progress. In this context, we can commit to exploring different mechanisms or opportunities in further developing relationships to support effective program delivery. **Action 3.1:** HQ to develop options with regions for different mechanisms to engage communities, make connections, and share information, including potential communications approaches that would benefit communities without adding to engagement fatigue. (Q1-Q2, 2024-2025) **Action 3.2:** Regions to invite communities to engage through the identified mechanisms, and explore with participating communities practical ways of continuing to seek feedback on communities' satisfaction with their relationships with ISC . (Q3, 2024-2025)	Director General responsible for Healthy Children, Youth, and Families, First Nations and Inuit Health Branch (FNIHB), Indigenous Services Canada (ISC) Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch (FNIHB), Indigenous Services Canada	*Start Date:* *April 2024* *Completion:* *March 31, 2025* *3.1 September 2024* *3.2 December 2024* *3.3 March 2025*	**Status:** ☐ Fully Implemented ☐ Partially Implemented ☐ Implementation did not Commence ☐ Obsolete **Update/Rationale:** **As of:** *(Insert Update Here)*

Recommendations	Actions	Responsible Manager (Title/Sector)	Planned Start and Completion Dates	Action Item Context/Rationale
	Action 3.3: HQ to compile a report, with input from regions, on the number of communities responsive to outreach, relationship building efforts, considerations related to establishing a baseline, and support for regions to develop plans to increase and support knowledge sharing across the HCD workforce. (Q4, 2024-25)			
4. Alongside First Nations partners, explore opportunities to revise and innovate performance measurement approaches, built upon appropriate data sources, to improve assessment of program impact, and which aligns with First Nations approaches, while maintaining a focus on reduced reporting burden.	We **do** concur. ISC-FNIHB recognises the need for performance measurement approaches built upon appropriate data sources that can provide an assessment of program impact without increasing reporting burden. Since the end of the evaluated period, ISC-FNIHB has taken steps that help address this recommendation, with additional related or wrap-up activities to come. In 2023, changes for HCD program data collection instruments were made and are being implemented for FY 2024/25. Additionally, ISC-FNIHB will be exploring opportunities to revise and innovate performance measurement approaches for Indigenous Early Learning and Childcare through the co-development process for an IELCC results framework. **Action 4.1:** Eliminate the CBRT and introduce a new Data Collection Instrument specific to the Healthy Child Development Program. Complete and implemented for FY 2024/2025. **Action 4.2:** ISC-FNIHB to review the results to date of the IELCC Results Framework that will be co-developed with the AFN, ESDC, and other government departments to determine whether aspects of the framework can be adopted to revise and innovate performance measurement approaches within the program to improve assessment of program impact. Results of review to be summarized in a report (Q4 2025-2026).	Director General responsible for Healthy Children, Youth, and Families, First Nations and Inuit Health Branch (FNIHB), Indigenous Services Canada (ISC)	*Start Date:* *March 2024* *Completion:* *December 2024* *4.1 Complete* *4.2 December 2024*	**Status:** ☐ Fully Implemented ☐ Partially Implemented ☐ Implementation did not Commence ☐ Obsolete **Update/Rationale:** **As of:** *(Insert Update Here)*

1.0 Introduction

The overall purpose of the evaluation was to examine the Healthy Child Development (HCD) group of programs, as outlined in the Five-Year Evaluation Plan at Indigenous Services Canada (ISC), and in compliance with the Treasury Board (TB) *Policy on Results*. The four program areas covered within the evaluation are: Aboriginal Head Start on Reserve (AHSOR) program, Fetal Alcohol Spectrum Disorder (FASD) program, Maternal Child Health (MCH) program, and Canada Prenatal Nutrition program (CPNP). The evaluation covers the fiscal years 2013-14 to 2018-19, and also considers the impacts of COVID-19. The total funding allocated to the HCD Program (including sub-programs and policy areas) from 2013-14 to 2018-19 was approximately $535,799,374.

2.0 Healthy Child Development Program Overview

2.1 Program Description

The First Nations and Inuit Health Branch (FNIHB) within ISC funds a suite of HCD programs and services, which are delivered by communities and aim to improve overall health outcomes for First Nations on-reserve and Inuit in maternal, infant, child, and family health. Activities include improving nutrition; promoting early literacy and learning; encouraging physical activities; promoting healthy relationships as well as emotional and mental health; promoting injury prevention and harm reduction; and promoting First Nations and Inuit culture.

The following outlines the sub-program areas included in the evaluation.

Maternal Child Health Program
MCH is a national program that is delivered in the community and builds on other community programs. The primary goal is to promote healthy pregnancies for First Nations women living on reserve, as well as Inuit women. Additionally, the program provides support to families with infants and children up to age 6. The MCH program includes components related to: case management; screening, assessment and referrals; and, health promotion strategies to improve maternal child health and identify risk factors for gestational diabetes, substance abuse, maternal and infant mental health issues, developmental delays that may impact a child's development, and family violence. It also provides support to address any issues identified by the family. The program aims to reach pregnant women and new parents through home visits by community nurses and experienced home visitors. Integrating culture into care is a key aspect of the program. Communities determine what aspects of the program they will deliver based on their unique needs and resources available. Program objectives include: increasing coordination of services for on-reserve clients, supporting greater First Nation control over the planning and delivery of services in communities, and increasing culturally sensitive and culturally relevant training opportunities for MCH service providers.

Fetal Alcohol Spectrum Disorder Program
The FASD program consists of mentoring, community coordinators, and capacity building. Through mentoring, home visitors build trusting relationships with women at risk of drinking while pregnant. Mentors provide ongoing, long-term support including assisting with setting goals and accessing services. Community coordinators act as case managers for children with FASD, including facilitating access to diagnosis and helping families connect with recommended services to put proper interventions in place. Finally, capacity building activities may include education, training, awareness raising, and the use of asset mapping tools to develop

community action plans. Starting in 2017, to increase program reach, some regions incorporated aspects of the FASD program in their MCH home visiting.

Canada Prenatal Nutrition Program
The CPNP First Nations and Inuit Component helps support the needs of pregnant women facing challenges that put their health and the health of their infants at risk.

The objectives of CPNP are as follows:

- Increase access to nutrition and lifestyle counselling, information, services, and resources to eligible First Nations and Inuit women, particularly those at high risk;
- Improve the adequacy of the diet of prenatal and breastfeeding First Nations and Inuit women, including increasing accessibility to prenatal vitamins, food and food coupons;
- Increase breastfeeding education, support, initiation and duration rates;
- Increase knowledge and skill building opportunities for those involved in the program, including food preparation training and education and support on infant care and child development;
- Increase the number of infants fed age-appropriate foods in the first 12 months;
- Increase accessibility of referrals to other agencies and services.

Aboriginal Head Start On-Reserve
The AHSOR program funds activities that support the learning and developmental needs of young children and their families living in First Nations communities. AHSOR programming focuses on six core elements: Culture and Language; Education; Nutrition; Social Support; Parental Involvement; and, Health Promotion. The goal is to support early child development strategies that are designed and controlled by First Nations communities. The Aboriginal Head Start On Reserve program has authority through the revised HCD Terms and Conditions to serve First Nations children 0-6 and their families, living on and off reserve.

2.2 Program Objectives and Expected Outcomes

The objective of the HCD program is to address the greater risks and lower health outcomes associated with First Nations and Inuit infants, children, and families. The logic model for the HCD program can be found in Appendix B. The following outlines the immediate, intermediate, and ultimate outcomes and objectives of the program:

Immediate Outcomes
i. *A trained workforce is in place to deliver HCD programs/services*.
ii. *First Nations and Inuit have access to HCD programs/services*

Intermediate Outcomes
i. *First Nations and Inuit are engaged in healthy behaviours*.

Ultimate Outcome
i. *First Nations and Inuit individuals and communities are healthier*.

2.3 Program Management and Key Partners

Program Management

FNIHB staff at the National Office within the National Capital Region lead strategic policy development and program planning in support of the HCD program, collaborating with FNIHB regional offices and First Nations and Inuit partners. The core responsibilities of National Office include program framework design; the national program funding allocations; national program monitoring; data collection and analysis; reporting and evaluation; provision of advice and/or guidance on program delivery; and working with First Nations and Inuit partners to ensure the effective delivery of HCD programming. The National Office may also issue and manage funding arrangements for national partners and stakeholders.

The FNIHB regional offices play a lead role in supporting communities with program delivery by working with First Nations and Inuit partners at the regional and local levels. The regional offices are also responsible for the management of funding arrangements, program performance monitoring, and information roll-ups. With the exception of the northern region, regions also support communities with program delivery.

The FNIHB Northern region works directly with the territorial governments and self-governing First Nations in Yukon and selected communities within Northwest Territories. In Nunavut and the remainder of Northwest Territories, the FNIHB northern region works directly with territorial governments to negotiate funding arrangements for health programming. Each territory is responsible to administer the funds to communities and organizations such as First Nations band councils, health authorities, Inuit associations, and voluntary and non-profit organizations. Programming is targeted to the entire population in each territory, not only First Nations and Inuit. As such, the HCD program in the North has unique reporting templates used to gather performance measurement information.

Communities or Tribal Councils are funded through funding arrangements to support the implementation and delivery of the HCD Program. Community or Tribal Council support includes building their internal capacity through the hiring and managing of community program staff, providing office space and program resources to staff, and working with regional offices to provide training for local staff.

Program Partners

To support program and service delivery, the HCD program collaborates with a number of other partners and stakeholders, including strong partnerships at the regional level with provincial programs and services that are integrated into FNIHB programming. For example, the HCD program works with:

- Other FNIHB program and service areas
- FNIHB regions;
- Other federal departments such as Health Canada, Crown-Indigenous Relations and Northern Affairs Canada, Employment and Social Development Canada;
- Provincial representatives; and
- Indigenous partners and organizations at national and regional levels.

Additionally, FNIHB's Senior Management Committee is the main decision-making forum for the Branch on issues related to policy development and priority setting. It includes representation from senior management at national office and regional offices and representatives from the Assembly of First Nations (AFN) and Inuit Tapiritiit Kanatami (ITK).

3.0 Evaluation Methodology

3.1 Scope and Evaluation Issues

The objective of the evaluation was to assess the relevance (continued need and responsibilities), as well as the performance in terms of effectiveness, efficiency, and economy, of the HCD programs that are part of the HCD program, highlighting the interconnectivity between the programs. The evaluation also considered promising practices and lessons learned to inform programs going forward, and drew attention to COVID-19, service transfer, and climate change as key thematic areas of focus. Evaluation questions are provided in Appendix A.

The evaluation covers the period from Fiscal Year 2013-14 to 2018-19 and is intended to serve as an evidence-based report to better inform decision-making for policy and program improvements, in line with the Treasury Board Policy on Results. It was conducted with consideration of Gender-Based Analysis Plus (GBA+) and the federal commitment to Truth and Reconciliation with Indigenous Peoples. More specifically, the Program was reviewed in the context of the Truth and Reconciliation Commission Calls to Action relating to Child Welfare, Education, Health, and Justice.

As previously mentioned, the evaluation scope encompasses the following programs: the MCH Program, the FASD Program, the CPNP, and the AHSOR Program.

All provinces and territories were included in the evaluation, except for British Columbia due to the *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Additionally, the evaluation was focused on First Nations contexts only, as a distinctions-based evaluation of Inuit-based programming will be conducted separately.

3.2 Evaluation Design and Methods

The evaluation was conducted by the ISC Evaluation Directorate in collaboration with Ference & Company Ltd., a third-party consulting firm. It utilized a mixed-methods approach that consisted of the following lines of evidence:

- A document and literature review;
- Key informant interviews:
    - 23 key informant interviews with ISC-FNIHB National and Regional staff members
    - Written submissions from two First Nation representatives (Chief, regional organization)
- 11 in-person visits to communities delivering programs funded through HCD, representing various contexts (i.e., region, geography/remoteness, population size, facilities, programs available):
    - 8 group or individual discussions with First Nations Health Directors, program coordinators, and staff delivering programs.
- Online survey:
    - 153 survey responses were collected from First Nations representatives delivering HCD programming across Canada (excluding BC). The survey was primarily completed by Health Directors, program staff and community health workers, and practitioners (e.g., dietitian, social worker, etc.).

3.3 Limitations

The table below describes the limitations encountered during the evaluation and the corresponding mitigation strategies utilized by the evaluation team to ensure data quality and the development of reliable findings.

Table 1. Limitations and Mitigation Strategies

Limitation	Mitigation Strategy
There was limited program performance data available to assess the achievement of outcomes and population-specific (i.e., GBA+) considerations. This is due to the nature of reporting data (i.e., primarily output-based), variation in reporting requirements (i.e., based on agreement type, variation by region) and increasing efforts to relax reporting requirements for communities.	Assessment of program impacts (including attention to GBA+) was collected through primary data collection (i.e., interviews, community site visits) and triangulated with program performance data to the extent possible. Additionally, the evaluation leveraged findings from population-level surveys where available (i.e., FNIGC Regional Health Survey) to capture changes in key outcomes.
The sample of First Nations communities included in site visits represents a very small percentage of all First Nation communities across Canada. Therefore, the data that emerged cannot be generalized to represent all First Nations delivering the programs. Additionally, communities that have higher capacity may have been more likely to agree to participate in visits.	The sample of communities were selected to reflect varying contexts including population size, geography/remoteness, facilities available, and types of programs delivered. Additionally, inclusion of an online survey was intended to expand opportunities for feedback to communities across Canada.
The evaluation experienced significant delays due to the COVID-19 pandemic. As a result, evaluation participants were asked to provide retrospective feedback on the program context prior to significant events (i.e., COVID-19) and some program changes (i.e., 2013-14 to 2018-19). There is a risk that participants inadvertently spoke to the present-day context. Additionally, historical knowledge of the program context and delivery was limited in some cases due to staff changeover.	In all invitations, prospective participants were advised of the evaluation timeframe and subsequently reminded throughout interview conversations.
The survey uptake differed considerably across regions, with a higher uptake in Alberta, Saskatchewan, and Ontario, and considerably lower uptake in the Northern and Atlantic regions.	To support uptake, ISC-FNIHB Regional Office staff in each region were notified at two separate intervals of the aggregate number of completed responses within their region and were encouraged to send follow-up reminders accordingly. Additionally, the findings from the survey were triangulated with other lines of evidence (i.e., regional engagements), to assess consistency where possible.

3.4 Indigenous Engagement

In terms of Indigenous engagement, the evaluation employed ISC-FNIHB's engagement protocol, which calls for National Indigenous Organizations (in this case, the Assembly of First Nations) to review evaluation documentation and comment/provide suggestions on the evaluation

methodology and questions to be asked. Furthermore, preliminary findings were also shared with AFN for review, validation, and feedback prior to the development of the final report.

Additionally, regional Indigenous partners (e.g. health partnership tables, tribal councils) were engaged by ISC-FNIHB regional offices on a less-formal basis to provide supplementary input on community selection, which was then passed along to the evaluation team.

3.5 Organization of Findings

The section below presents the key findings that emerged from the evaluation, organized by evaluation issue. To reduce redundancy and support a coherent narrative, some evaluation questions have been integrated/consolidated to focus on an overall issue.

Primarily, the HCD sub-programs were considered and reported holistically. With that being said, findings 14-17 are focused on their individual performance on a sub-program level.

4.0 Key Findings: Relevance

4.1 Program Relevance

Finding 1: The HCD program is relevant as there is an ongoing need to support and invest in the well-being of First Nations children and families through early childhood programming. The program also supports broader departmental mandates for supporting healthy individuals and communities and reducing gaps in inequity, and directly aligns with Calls to Action from the Truth and Reconciliation Commission (TRC).

Findings across all lines of evidence indicate that HCD program funding remains relevant to First Nations' needs as its range of activities are supporting access to many of the determinants of infant, child, maternal, and family well-being. To illustrate, community programs showcased in the evaluation were designed to strengthen connection to culture-based practices and activities, build life-skills (e.g., parenting, cooking, grocery shopping, budgeting), increase access to nutritious foods and infant supplies, foster group-based learning (e.g., breastfeeding groups, parent groups), and support connection with the broader community and network of supports. According to a report by the National Collaborating Centre for Indigenous Health, investing in quality early child development programs such as these are critical to closing the gap in health outcomes between Indigenous and non-Indigenous peoples as the programs provide a strong foundation for healthy development, which supports children over the life course. Additionally, the report notes that strong attention to early child development is a priority as Indigenous peoples are among the youngest and fastest growing segment of Canada's population; Indigenous children continue to experience inequitable health and social outcomes as a result of colonization (see: 4.2); and population growth has outpaced current funding models.[2] This was echoed by community-based representatives, who described an ongoing priority for early intervention and prevention programs that support First Nation families and children in early life.

The HCD program also aligns with ISC departmental mandates and priorities. Specifically, HCD supports ISC's departmental results under the Health service area in the 2023-24 Departmental Results Framework: "Indigenous Peoples are physically well"; "Indigenous Peoples are mentally well"; and "Indigenous Peoples have access to quality federally-funded health services."[3] Additionally, HCD supports the overall mandates of ISC to improve access to high-quality services, improve well-being, and support Indigenous peoples in assuming control of the delivery of services.[4] To illustrate further, the 2017 Prime Minister mandate letter to the Minister of Indigenous Services states that among the top priorities is "a holistic approach to the delivery of services that focuses on prevention, family preservation and well-being, and community wellness."[5]

Federal budget announcements over the evaluation timeframe indicate growing attention to First Nations infant, child, maternal, and family health. Budget 2018 acknowledged that among the significant gaps in health outcomes between Indigenous and non-Indigenous peoples, "infant mortality rates of First Nations and Inuit children are up to three times higher," which can be narrowed by providing access to "quality health care close to home."[6] Budget 2017 also

[2] Halseth, R. and Greenwood, M. (2019). Indigenous Early Childhood Development in Canada: Current state of knowledge and future directions. National Collaborating Centre for Aboriginal Health. https://www.nccih.ca/docs/health/RPT-ECD-PHAC-Greenwood-Halseth-EN.pdf
[3] ISC. (2023). Indigenous Services Canada Departmental Plan 2023-24 . https://sac-isc.gc.ca/eng/1666289629121/1666289645507
[4] ISC. (2020). Indigenous Services Canada Strategic Plan 2020-2025. https://www.sac-isc.gc.ca/eng/1580929468793/1580929551018
[5] Office of the Prime Minister. (2017). Minister of Indigenous Services Mandate Letter. https://caid.ca/PhilpottISMandate2017.pdf
[6] The Department of Finance of Canada. (2018). Budget 2018 Equality and Growth: A Strong Middle Class. Ottawa.

included a focus on improving First Nations health outcomes through investing $828 million over five years to enhance and expand programming, including maternal and child health services (i.e., MCH, FASD) in First Nations and Inuit communities. Additionally, Budget 2017 announced investments in the development of a National, Distinctions-based Indigenous Early Learning and Child Care Initiative (IELCC) framework through $1.7 billion over a period of ten years (2018 – 2028).[7]

Investment in programs and supports for First Nation children and families align with the TRC Calls to Action to address inequities and improve outcomes. Among many recommended actions, the TRC called on the federal government to collaboratively develop culturally appropriate parenting programs (Call to Action #5), FASD preventive programs (#33), and early childhood education programs (#12), and establish measurable goals to identify and close the gaps in health outcomes (including, infant mortality, maternal health, infant and child health) (#19).[8]

4.2 Health and Social Needs Impacting First Nations

Finding 2: First Nations communities and the broader research report ongoing experiences of health and social inequities among children and families – including, nutrition and food insecurity, chronic disease, and poorer birth outcomes. Almost all (89%) community representatives surveyed reported that there is a continued need for programming, and that needs appear to have risen in acuity and complexity.

First Nations communities are delivering HCD programs across a wide range of contexts (e.g., geography, population size, capacity) and in-line with identified priorities and needs. The paragraphs below describe the most consistently identified needs, however it is important to acknowledge that communities are highly diverse, and many First Nations children and families are enjoying good health. Poorer achievement of indicators of health among some children and families must also be positioned within the broader social, political, economic, and historical contexts, which continue to impact children, women, and families as colonial policies have functioned over generations to displace and disrupt family structures.

Overall, findings from the literature suggest that some First Nations infants, children, women, and families continue to experience poorer health outcomes as measured by indicators including access to nutrition and food insecurity, chronic disease, and birth outcomes.[9] The sections below describe the primary literature findings.

Nutrition and Food Security

Access to nutrient-dense foods, including through traditional food systems, have important benefits to overall health and well-being of children and families. However, many First Nations children and families lack access to nutritious foods due to interrelated factors including geography/remoteness, environmental disruption and/or lost access to traditional food systems, and poverty.[10] According to the First Nations Food, Nutrition, and Environment Study

[7] The Department of Finance of Canada. (2017). Budget 2017 Chapter 3 – A Strong Canada at Home and in the World. Ottawa.
[8] Truth and Reconciliation Commission of Canada. (2015). TRC Calls to Action. https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf
[9] Halseth, R. and Greenwood, M. (2019). Indigenous Early Childhood Development in Canada: Current state of knowledge and future directions. National Collaborating Centre for Indigenous Health. https://www.nccih.ca/docs/health/RPT-ECD-PHAC-Greenwood-Halseth-EN.pdf
[10] Earle, L. (2011). Traditional Aboriginal diets and health. National Collaborating Centre for Indigenous Health. https://www.nccih.ca/495/Traditional_Aboriginal_diets_and_health_.nccah?id=44

(FNFNES), the prevalence of food insecurity was found to be high (48%) among First Nations communities, with rates across regions estimated to be 3-5 times higher compared to the general population (12%). Food security rates were also found to be particularly high in remote communities, which may be due to poorer access to affordable, nutritious foods compared to in urban areas.[11] Similarly, Phase 3 of the Regional Health Survey (RHS) found that the rates of food insecurity have decreased minimally since Phase 2, evidenced by 43% of households with children classified as food insecure.[12]

Chronic Disease

The Phase 3 RHS report notes that First Nations across the life course continue to be disproportionately impacted by chronic disease and associated risk factors (including, diabetes, arthritis, high blood pressure, allergies and chronic back pain). The inequitable experience of chronic disease must be rooted within the broader context of colonization and generations of colonial policies, leading to environmental dispossession and land degradation, overcrowded and substandard housing, exposure to environmental contaminants and poor drinking water, poor access to health services and diagnostic supports, dislocation from community, land, language, and culture, and geographic isolation. RHS Phase 3 found that a significantly higher proportion of First Nations females (46.5%) reported co-morbidities compared to First Nations males (36.4%); this finding was consistent with RHS Phase 2, suggesting that females continue to be at a higher risk. Additionally, nearly thirty percent (28.5%) of all children reported being diagnosed with one or more chronic health conditions (most commonly, allergies, asthma, speech or language difficulties, dermatitis/eczema, and chronic ear infections). Furthermore, rates of Type 2 diabetes continues to be an area of concern among some First Nations communities, particularly impacting women, children and youth.[13]

Pregnancy Outcomes and Infant Health

Access to appropriate prenatal and maternity care among some First Nations women may be limited by factors including geography and distance to care, systemic racism and lack of cultural safety, and barriers imposed by jurisdictional divisions in care between federal and provincial/territorial governments. Poor access to high quality and respectful care alongside socio-economic inequities can increase the risk of adverse outcomes for women and infants. While there are gaps in data on birth outcomes, the available research suggest that indicators including infant mortality, preterm birth, and birthweight appear to be poorer among First Nations.[14] A report by Statistics Canada (2004-2006 census-lined birth cohort) estimates that infant mortality rates are more than twice as high for First Nations, Inuit, and Metis, compared with non-Indigenous people. Additionally, rates of sudden infant death syndrome may be more than seven times higher among First Nations and Inuit.[15]

[11] Assembly of First Nations, University of Ottawa, Universite de Montreal. (2021). First Nations Food, Nutrition and Environment Study – Summary of Findings and Recommendations for eight Assembly of First Nations regions 2008-2018. https://www.fnfnes.ca/docs/CRA/FNFNES_Report_Summary_Oct_20_2021_FINAL.pdf

[12] First Nations Information Governance Centre, National Report of the First Nations Regional Health Survey Phase 3: Volume Two, (Ottawa: 2018). Published in July 2018.

[13] First Nations Information Governance Centre, National Report of the First Nations Regional Health Survey Phase 3: Volume Two, (Ottawa: 2018). Published in July 2018.

[14] Halseth, R. and Greenwood, M. (2019). Indigenous Early Childhood Development in Canada: Current state of knowledge and future directions. National Collaborating Centre for Indigenous Health. https://www.nccih.ca/docs/health/RPT-ECD-PHAC-Greenwood-Halseth-EN.pdf

[15] Statistics Canada. (2017). Birth outcomes among First Nations, Inuit and Métis populations. Health Reports. https://www150.statcan.gc.ca/n1/pub/82-003-x/2017011/article/54886-eng.htm

Community Perceptions of Needs

Almost all (89%) community representatives who responded to the survey strongly agreed or agreed that there is a continued need for HCD programming in their community (8% neutral; 1% strongly disagree; 1% responded don't know; n=153). Qualitatively, evaluation contributors described a wide range of needs observed among children and families. This includes supporting families to meet basic needs (e.g., access to affordable and appropriate foods, infant formula, children's activities and supplies), strengthening the skills and knowledge of parents/caregivers, prevention and intervention support for children and caregivers experiencing challenges (e.g., who use substances, live in precarious environments, lack support systems), and connecting and revitalizing language and culture-based practices.

In the context of COVID-19 and other compounding challenges – including inflationary pressures, drug-related emergencies, and grief and trauma from the discovery of unmarked graves – the needs are reported to have risen in acuity and complexity for some First Nations – this includes heightened food insecurity and poverty, more prevalent developmental delays among children, and more complex substance use (e.g., opioid use, methamphetamine).

4.3 Duplication or Overlap

Finding 3: Owing to their unique purpose of supporting maternal health and child development, the HCD programs are not duplicating other programs/services on reserve. Communities may access funding through complementary funding opportunities (e.g., other federal departments, provincial governments) in an effort to enhance ongoing programming and address underfunding.

The evaluation found that the HCD programs do not duplicate other programs/services as they uniquely support the design and delivery of community-based, pregnancy/maternal health and early childhood development programs on-reserve.

During the evaluation timeframe, four federal departments (inclusive of ISC) were primarily involved with program and policy development for Indigenous children and families.

- the Public Health Agency of Canada provides funding for children and families off-reserve, including the Aboriginal Head Start in Urban and Northern Communities, Community Action Program for Children, Canada Prenatal Nutrition Program, and Fetal Alcohol Spectrum Disorder Program;
- Employment and Social Development Canada provides funding for the First Nations and Inuit Child Care Initiative;
- the former Department of Aboriginal Affairs and Northern Development provided day-care programs for some First Nations on reserve (i.e., Ontario, Alberta).

Additionally, Infrastructure Canada and Heritage Canada were mentioned by some key informants as relevant to the HCD Programs as they can support communities with infrastructure needs and enhance culture-based activities, respectively.

A report by Canada's Public Policy Forum notes that the existence of multiple funding departments can add burden to Indigenous funding recipients due to time required to secure funding from each department, navigate multiple agreements, and fulfil varying reporting requirements. Furthermore, differences in funding models and Terms and Conditions across

departments can limit the pooling of resources to deliver enhanced programming.[16] While not within the evaluation scope, this was identified by some key informants particularly as it relates to the IELCC initiative and the risk of administrative burden on communities managing funding arrangements with ESDC and ISC.

Provincially, some complementary services were identified. For example, the Healthy Baby program in Manitoba provides supports for eligible women on reserve to access funds for pre-natal nutrition; communities in Ontario may pool funding with the provincial Healthy Babies Healthy Children program. The extent to which children and families may have access to complementary provincial services was not determined, though it was noted in reporting that First Nations families may be denied access to provincial services adjacent to reserves due to ongoing jurisdictional disputes.[17]

According to the community-based survey and community site visits, few respondents reported that there was duplication or overlap between HCD and other programs in the community. To illustrate, 18% of survey respondents strongly agreed or agreed that HCD duplicates other programs, 37% were neutral, and 35% strongly disagreed or disagreed (n=153 overall). In interview discussions with both ISC and community-based representatives, HCD funding was often described as insufficient as a standalone source of funding; to mitigate this, communities may supplement ISC funding with other sources (e.g., provincial funding, other federal department funding, donations, etc.) and/or enhance programming through Jordan's Principle.

[16] Canada's Public Policy Forum. (2015). Building Leaders – Early Childhood Development in Indigenous Communities. Final Report.
https://ppforum.ca/publications/building-leaders-early-childhood-development-indigenous-communities/
[17] Ibid

5.0 Key Findings: Effectiveness

5.1 Achievement of Outcomes

Immediate outcome #1: A trained workforce is in place to deliver HCD programs/services.

Finding 4: There were increased efforts to support community-determined training and workforce development throughout the evaluation timeframe. However, recruitment and retention of a trained workforce was identified as a considerable challenge to effective program delivery.

According to the 2018 Performance Information Profile, an annual template may be circulated to regional offices to collect data on training-related indicators (i.e., number of workers who have received training). However, reporting data was not available at the time of the evaluation to quantitatively assess this outcome.

Qualitatively, key informants described an evolving picture of supports for training and workforce development. During the earlier years of the evaluation, relevant training was primarily delivered by FNIHB regional offices to community workers according to program mandates. However, in-line with strategic efforts to support local decision-making over program delivery, funding for training was largely re-directed to communities. Several avenues for training access were identified by regional and community-based staff, including through local colleges/universities (e.g., home visitor training, early childhood educator training), conferences, and regional First Nations service delivery partners. The extent to which funding levels were appropriate to accessing training was unclear, though several related considerations for workforce development were identified.

Most critically, retention of a trained workforce was described as an ongoing challenge as communities may not be able to recruit qualified staff due to low wages available, and/or staff are lost to higher paying positions, such as equivalent provincially-funded services, upon receiving training. Approximately half of community-based representatives surveyed indicated that there is a lack of qualified staff to deliver HCD programming (45% disagreed or strongly disagreed) and that staff turnover causes challenges to program delivery (51% disagreed or strongly disagreed).[18] These challenges appear to be particularly evident for remote and isolated communities as staff are often expected to fulfil multiple program/service offerings for families with limited access to appropriate training and supports. In turn, program quality and access may be constrained as the skillset and capacity of staff may not be commensurate with the needs experienced within communities.

Achieving a trained workforce is further complicated by reports of rising and more complex needs. Some regional staff and community representatives noted that changing substance use patterns (e.g., use of stimulants), violence in community, and higher needs among children (e.g., developmental delays) has led to increased pressures on staff and the need for an expanded skillset.

[18] 31% of survey respondents strongly agreed or agreed that there are enough qualified staff to deliver programming, 19% were neutral, 45% strongly disagreed or disagreed, 6% responded “don’t know” (n=141)

39% of survey respondents strongly agreed or agreed that staff turnover does not cause challenges, 21% were neutral, 51% strongly disagreed or disagreed, 4% responded “don’t know” (n=141)

> *The skillset required for workers is really changing. When the MCH program came out, it was based on their favourite auntie going out and helping people connect with programs and encouraging them to come in. It's different now, there are more complex needs. The assessment tool we have is more simplistic than what we're seeing now.*

To address changing population needs and further align programs to community priorities, several training needs were identified (outlined below). Additionally, community-based staff consistently described an interest in knowledge sharing opportunities (e.g., annual gatherings, virtual networks) to debrief and share promising practices and lessons learned.

- **Trauma-informed training** to improve support for children and families impacted by various forms of trauma,
- **Culturally relevant training, including traditional teachings** to center First Nations practices and worldviews in programming,
- **Expanded home visitor training** with a focus on safety training and supporting clients with complex needs, including substance use,
- **Resources to support families and children with higher needs** (e.g., children with developmental delays; FASD; Attention-Deficit / Hyperactivity Disorder, ADHD; autism spectrum disorder, ASD)

Immediate outcome #2: First Nations have access to HCD programming.

Finding 5: Increased investment at the end of the evaluation timeframe (i.e., Budget 2017) supported the HCD program to expand overall program coverage. However, continued effort to achieve universality is needed.

On a community level, the HCD programs are reaching community members through providing essential resources/supplies (e.g., infant formula, grocery vouchers, meal kits), attending home visits, facilitating referrals, and delivering group-based programming (e.g., breastfeeding and parenting support, meal preparation, culture-based activities).

Access to programming was assessed both overall (i.e., program coverage) and on a community-level (i.e., types of services and activities available).

Program Coverage

With respect to program coverage, key informants noted that the lack of universal access to the HCD programs is an ongoing challenge limiting program effectiveness. While quantitative data detailing overall coverage was not available, one key informant within ISC estimated that only one third of all First Nations communities have access to the MCH and FASD programs, as an illustration of limited reach.

Static and insufficient funding throughout most of the evaluation timeframe (i.e., 2013-14 to 2016-17) was described as the primary barrier to expanding access and ultimately achieving universal coverage. Based on 2017 data, regions generally used two distinct approaches in an effort to optimize program funding. Some regions adopted a "universal" approach through

distributing funds for programming among all communities. While this has the advantage of providing all communities with some funding, fulsome program delivery is greatly limited. Other regions utilized a more targeted approach to funding programming, which had the advantage of providing selected communities with full programs, though leaving others without access.

Program access and quality appears to have increased towards the end of the evaluation with the introduction of additional investments in some program areas through Budget 2017 and IELCC.[19] In particular, these funding increases were described as significant to addressing historic underinvestment, increasing coverage of the programming, and expanding the range of services/activities that communities could offer. For example, increased investments enabled the Alberta region to move forward with a model whereby all Nations receive either MCH or FASD program funding allocations. In other regions, Budget 2017 funding enabled outreach programs (e.g., AHSOR) to grow to centre-based programming. One regional staff described the following impacts:

> *"[Budget 2017] investments allowed communities to offer more in terms of salary to retain experienced staff. Some communities creatively developed three-year programs focused on maternal and child health and were able to offer very innovative and collaborative programs, sometimes with their social departments to address things like life skills, gestational diabetes (…) those new investments allowed them to address priorities."*

As the funding was distributed late in the evaluation, a more fulsome understanding of the long-term impacts as a result of these investments is expected to emerge in the next evaluation.

Program and Service Access

Findings from community-based staff suggest that the HCD programs are contributing to access to several determinants of maternal, child, and family well-being. Communities engaged in the evaluation reported supporting families through providing essential resources/supplies (e.g., infant formula, grocery vouchers, meal kits), attending home visits, facilitating referrals, and delivering group-based programming (e.g., breastfeeding and parenting support, meal preparation, culture-based activities).

Furthermore, the program's Performance Information Profile (PIP) outlines several measures of program access that are gathered through data from the community-based reporting template (CBRT). Demonstrated in the table below, CBRT data suggests that, over time, an increased proportion of communities offered group breastfeeding support activities and screened for risk factors for developmental milestones through HCD programming. Additionally, reporting data indicates that the proportion of pregnant women receiving nutrition education was relatively stable. However, as the CBRT is a data collection tool that is utilized only by some communities depending on their funding agreement type, findings must be interpreted with caution as they do not reflect all communities delivering the HCD programs.

[19] Through Budget 2017, $828 million was invested over five years in maternal and child health (MCH, FASD programming), mental wellness, harm reduction measures for addictions, home and palliative care, primary care, and infectious disease prevention. Additionally, the National IELCC was allocated $1.7 billion over a period of ten years (2018 – 2028). Core programs that fall under the IELCC umbrella include: Aboriginal Head Start in Urban and Northern Communities (AHSUNC), AHSOR, and the First Nations and Inuit Child Care Initiative (FNICCI). The overall goal of the increased funding is to provide Indigenous children with high-quality and culturally appropriate early learning and child care.

Table 2. Achievement of access-related performance measures as identified by program PIP, based on CBRT annual reporting data[20]

Performance Indicator outlined in PIP	2013-14 CBRT	2014-15 CBRT	2015-16 CBRT	2016-17 CBRT	2017-18 CBRT	2018-19 CBRT	Target
% of First Nations communities with maternal and child health programming that provide group breastfeeding support activities.	47.7%	49.7%	51.6%	50.7%	50.2%	52%	**50% (2019)**
% of pregnant women who received nutrition education in the 1st, 2nd, or 3rd trimester	79.9%	77.8%	81.6%	78.1%	79.7%	79%	**79% (2019)**
% of First Nations communities that screen for risk factors for developmental milestones through participation in HCD	68.7%	68.8%	68.9%	70%	71.4%	71%	72% (2019)

While community-based representatives spoke to the many strengths of the HCD programs delivered in community, stagnant funding was reported across all lines of evidence as a significant hurdle to offering comprehensive supports for children and families.

As a result of limited funding, not all communities have access to promising practices within the programs (e.g., home visitation model, peer mentoring) and staff report difficulty responding to changing needs and priorities (e.g., population growth, service demand). This has also impacted the extent to which communities can integrate traditional activities into programming as the appropriate compensation of Elders and purchasing of supplies exceeds funding available. In turn, children and families were described by some community representatives as "falling through the cracks" as program staff are not able to sufficiently reach all families and provide the necessary early intervention and prevention assistance.

> *"We still try to service the same amount [of families], but we can't offer them what we used to offer them. (…) We would give $20 every two weeks for nutrition for our breastfeeding moms, but $20 doesn't go far anymore. We are trying to think outside the box and offer a fresh food market so that they can come and get cheaper fruits and veggies in the community. Funding impedes our ability to offer all of the services we want, and even to cover rent for a physical space."*

Intermediate outcome #1: First Nations are engaged in healthy behaviours.

Finding 6: The available data suggests that the HCD programs are supporting achievements for both families (e.g., skills and awareness, resilience, positive identity, early intervention) and the community at large (e.g., service linkages, community cohesion). Reporting data also indicates that improvements have been made in breastfeeding rates. However, poor access to

[20] FNIHB (2014-2019). Community-Based Reporting Templates (CBRT) – National Summary Reports for the Fiscal Years 2013-14 – 2018-19.

the social determinants of health limits the achievement of true behaviour change and long-lasting outcomes for many children and families.

Overall, there was limited quantitative data to assess improvements in healthy behaviours. Although, findings from the RHS Phase 3 point to a decrease in the prevalence of smoking during pregnancy (37.5% in Phase 3 compared to 46.9% in Phase 2), and a decrease in the prevalence of FASD over time (0.5% in Phase 3 compared to 1.8% in Phase 1).[21] While it is not possible to attribute this to the HCD programs, this suggests that First Nations communities are achieving overall improvements in healthy behaviours over time.

Most community-based survey respondents (75%) strongly agreed or agreed that they had observed changes in their community because of funding and support through the HCD program (n=153; Figure 1). Through interviews and in-person site visits, a wide range of achievements were described for both families and the community at-large as a result of the programs.

- **Individual and family outcomes:** Among the wide range of outcomes reported, the programs are increasing knowledge and skill-building opportunities for new and expectant parents (e.g., baby food making, cooking skills, infant safety and development, parenting skills); improving access to essential needs (e.g., grocery vouchers, food hampers, transportation support, infant supplies); building resilience and a positive cultural identity; and revitalizing and connecting families with culture-based practices and traditions. Furthermore, program participation was attributed to outcomes such as improved early intervention and prevention response (e.g., for people with addictions, for children flagged as “at risk”) and access to screening, increased achievement of growth and development milestones among children, and increased school readiness.

- **Community-level outcomes:** The programs were often described as a source of pride and strength as they support community building and foster the development of strong networks between children, caregivers, families, staff, and organizations. HCD program staff play an important role in referrals and linkages with other programs/services, such as with specialized health professionals (e.g., connecting families with speech language pathologists, community health nurse, occupational therapists, mental health therapist) and other programs and initiatives (e.g., Jordan’s Principle, Non-Insured Health Benefits). Relatedly, HCD programs have also improved access to essential services (e.g., prenatal nutrition, early childhood education, support for children with FASD) that otherwise are not available in community – particularly for remote and isolated First Nations.

[21] First Nations Information Governance Centre. (2018). National Report of the First Nations Regional Health Survey Phase 3: Volume One. Ottawa.

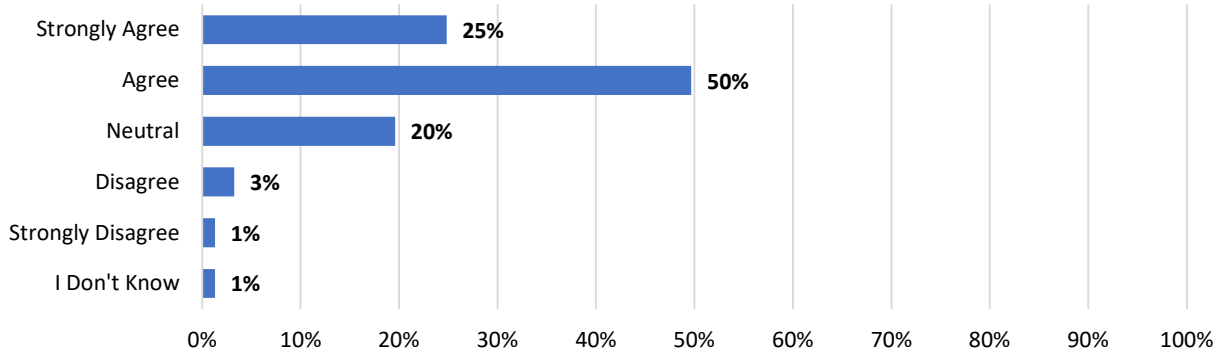


Figure 1. Survey respondent level of agreement with the statement: "You see changes in your community because of funding and support through HCD services" (n=153)

In addition, data from the CBRT suggests that breastfeeding outcomes may have improved over time among women who accessed services through the Maternal Child Health program (see table below). Some community-based staff also reported improvements in breastfeeding rates, which was facilitated by activities such as breastfeeding circles as they encourage women to gather, seek advice and support, and build trusting relationships with staff in the community.

Table 3. Proportion of women accessing MCH program activities who breastfed for 6+ months, based on CBRT data[22]

Performance Indicator	2013-14 CBRT	2014-15 CBRT	2015-16 CBRT	2016-17 CBRT	2017-18 CBRT	2018-19 CBRT	Target
Percentage of women in First Nations communities accessing maternal and child health program activities who breastfed for 6 months or more.	24.8%	26.4%	31.7%	28.5%	29.4%	28%	32%

However, it is important to note that while program accomplishments are reported, the evaluation found that the achievement of true behaviour change, and long-lasting outcomes is constrained as many communities continue to experience poor access to the social determinants of health. Therefore, the limited program funding available through HCD is, in some cases, predominantly focused on meeting immediate access needs (e.g., groceries, supplies, infant resources). This points to both a strength in funding flexibility and an ongoing need to devote resources and coordinated action to address inequitable access to the determinants of health and well-being.

5.2 Service Gaps

Finding 7: Two service gaps were identified. Firstly, the lack of universal access to the HCD programs across First Nations communities despite evidence of need. Additionally, limited availability of programming/service interventions to support youth, which may be due to a

[22] FNIHB (2014-2019). Community-Based Reporting Templates (CBRT) – National Summary Reports for the Fiscal Years 2013-14 – 2018-19.

combination of factors including the entrenchment of historical program parameters (i.e., limiting services to birth to age 6), and deficiencies in funding to offer expanded programming.

Two primary service gaps were identified through the evaluation: lack of universal access, and age-related gaps in programming.

Universality

As previously mentioned, key informants identified the lack of universal access to the HCD programs in all First Nations communities as a critical service gap. As a result, not all First Nations children and families have equal access to services that are widely considered essential for promoting healthy development, preventing poor outcomes, and intervening during critical years to support a positive trajectory. This is echoed in the First Nations Health Transformation Agenda, which recommends investments to support universal access to both the MCH and AHSOR programs in all communities. According to the report, 17% of children on reserve currently have access to Head Start, and it is estimated that annual funding for AHSOR must be $347 million to provide universal access.[23]

Age-related Gaps

A common theme shared across interviews and community-based site visits was a perceived gap in services and programming for children above age 6. Support for prenatal care to age six remains a priority, though some noted that the subsequent absence of funding for youth-based programming has led to vulnerability as early prevention activities are not undertaken, particularly in remote and isolated communities (i.e., due to lack of facilities and limited extra-curricular activities). Similarly, the First Nations Health Transformation Agenda (HTA) notes that: "the need for childhood development programming does not end at six years old, particularly given the ongoing challenges of underfunding for on-reserve schools. Therefore, the [AHSOR] program must expand to include children over six years." This is also reiterated in the HTA for the MCH program.[24]

According to the Terms & Conditions (T&Cs) of the program, the language states that the AHSOR program as a sub-sub activity "will (…) serve all First Nations children 0-6 and their families (…)."[25] However, more broadly, the HCD program's eligible activities do not specifically restrict programming after age 6. ISC staff noted that this discrepancy may be due to historical program guideline development, which may have introduced an age limit in an effort to further scope activities. While the T&Cs do not specifically restrict overall program activities by age, the absence of youth-based programming must be positioned within the broader context of insufficient funding to deliver comprehensive services.

5.4 Program Interconnectivity and Collaboration

Finding 8: Interconnectivity was assessed in three ways: interconnectivity *within ISC, between* ISC and communities, and *within* community.

Collaboration within ISC appeared to be generally effective and the division of roles and responsibilities was deemed appropriate.

[23] Assembly of First Nations. (2017). First Nations Health Transformation Agenda. https://scoinc.mb.ca/wp-content/uploads/2021/06/FNHTA-AFN-wcag.pdf
[24] Assembly of First Nations. (2017). First Nations Health Transformation Agenda. https://scoinc.mb.ca/wp-content/uploads/2021/06/FNHTA-AFN-wcag.pdf
[25] ISC. (2020). Primary Health Care Authority. Primary Health Care Authority (sac-isc.gc.ca)

There are opportunities to improve relationship building efforts and increase engagement between regional staff and communities – this would support information sharing and program updates and build understanding of the realities of service delivery.

Lastly, programs within community appear to be collaborating effectively, owing to their complementary mandates. Community-based staff may deliver several program areas as one holistic initiative and/or pool funding across program areas to enhance service offerings.

Interconnectivity: ISC and Community

Evaluation contributors were asked to reflect on the clarity and effectiveness of relationships between communities and ISC regional offices, and between ISC regional offices and the national office.

According to the community survey, 37% of respondents strongly agreed or agreed that the relationship between communities and the ISC regional office is clear and effective (33% were neutral, 21% disagreed or strongly disagreed, 9% don't know; n=153). All community representatives engaged through in-person visits expressed a desire for more direct communication and engagement with regional ISC staff, such as information/resource sharing and more frequent community visits. More frequent interactions would support better collaboration, showcase innovation, and facilitate a stronger understanding of program realities and constraints. Challenges associated with staff turnover within ISC regional offices was also identified by some representatives. Comparatively, regional office staff perceived relationships to be effective and spoke to an increasingly "hands-off" approach that supports communities where possible and minimizes hurdles to support local control over program delivery.

ISC regional and national office staff agreed that their relationship was effective, and that the division of roles was appropriate to supporting regional autonomy and local innovation. The increasing focus away from headquarters and toward regional and local decision making was described as a positive change observed over the evaluation timeframe. The use of cluster meetings which gather national and regional staff was cited as effective, however some regional staff expressed an interest in more engagement and communication with national office representatives to ensure their priorities were heard.

Interconnectivity: Program Level

Both ISC and community-based respondents spoke to the complementarity and collaboration occurring across HCD programs and beyond. For instance, community-based staff may hold multiple roles across programs (e.g., one staff may be both a MCH and FASD home visitor) and/or collaborate with other staff to deliver activities in conjunction. In particular, the CPNP, FASD, and MCH programs were frequently reported to be delivered as a combined program due to their close alignment in scope and mandate.

According to the survey, approximately half (54%) of respondents agreed or strongly agreed that programs within HCD are collaborating, and 40% agreed or strongly agreed that relevant partnerships with other community stakeholders are established to support HCD Programs. In both cases, several respondents (>30%) felt neutral. With respect to partnerships with other community stakeholders, community-based staff frequently reported collaborating with Jordan's Principle to support children and families to access necessary services and supports.

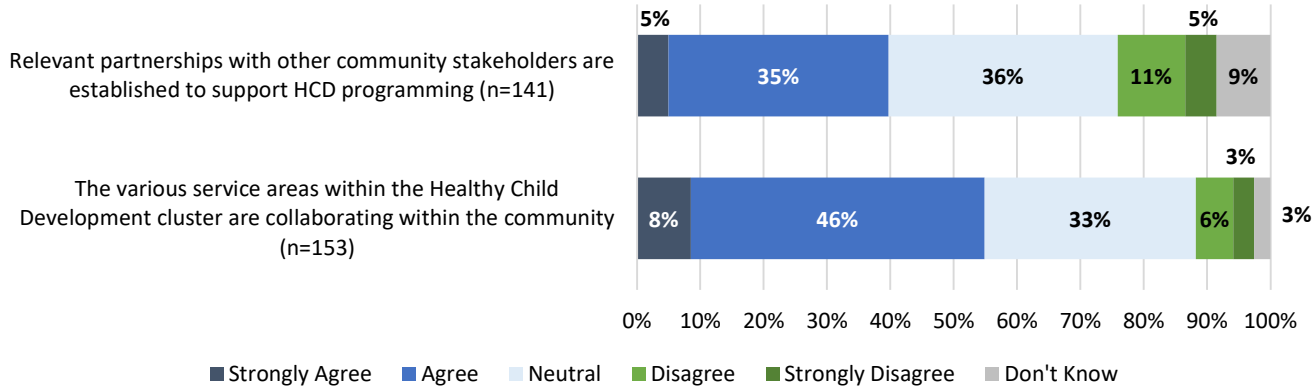


Figure 2. Level of agreement with the achievement of partnerships and collaboration within and outside of HCD programs delivered in community

Efforts to collaborate across program areas have several advantages, including enabling more holistic service delivery and creating a circle of care where children and families are brought into a broader network of supports. For example, one community described offering wrap-around programming in collaboration with peer mentors, the community health nurse, daycare and AHSOR, and the school – often focused around a monthly theme/topic. This approach helps to "link and pull people in."

Community-based representatives frequently emphasized the strength of, and priority for, holistic interventions, noting that it is impossible to support child development without incorporating the social determinants of health and acknowledging the historical, traditional, and cultural dimensions of well-being. For example, as many parents are impacted by intergenerational trauma enacted by residential schools, Indian day schools, and the sixties scoop, any programming focused on children must also engage parents to build healthy parenting skills and support healing.

Given the close alignment across programs, some key informants both within ISC and on a community-level noted that the siloed approach to funding within ISC (i.e., particularly for FASD, MCH, CPNP as separate programs) does not align with community preferences and realities of holistic programming. Furthermore, the functional division across programs may add unnecessary reporting and administrative burden. Some also indicated that the entrenchment of siloed funding streams may create confusion and dissuade more comprehensive programming, even if agreement holders are in more flexible arrangements.

> *As a group [of programs], I think they work well together, but we could be doing more from our perspective (ISC) to erase the lines in between to make it more holistic and comprehensive. I'm still reminding people often that they can work together on different programs, it doesn't matter if you're a FASD or MCH worker. They can work together on these.*

5.5 Regional Differences

Finding 9: The realities of program/service delivery vary across regions as a result of several factors (e.g., geography, jurisdiction, population, priorities). This includes variation in

approaches to funding (e.g., universal or targeted, cluster-based funding), combining of programs, and involvement of regional organizations in program oversight.

Owing to several factors including geographic realities, population size, jurisdictional context, partnership structures, and local priorities – differences in regional program funding and implementation were documented and reported.

For example, with respect to funding approaches, regions have adopted either a "universal" or targeted approach to HCD funding. The Atlantic (33 communities), Quebec (55 communities) and Ontario (133 communities) regions generally adopted a "universal" approach, distributing funds for healthy child development programs among all communities. Conversely, the Manitoba (63 communities) region carried out implementation of MCH, FASD and AHSOR in targeted communities, while Saskatchewan (85 communities) and Alberta (47 communities) regions took the same approach with MCH and FASD. According to program documents, the resulting implications are that children's programming, although described as "universal" in some regions remain only partially funded, while Manitoba, Saskatchewan, and Alberta are struggling to expand access to all communities.

Additional examples of regional activities as reported and described by key informants are shared below:

- In the Ontario region, funding is delivered through a cluster-based model whereby communities have flexibility to allocate funding toward AHSOR, FASD, and MCH programs based on their identified priorities. The CPNP program funding is separate from cluster funding and allocated specifically for CPNP activities. Though this flexibility offers a higher level of autonomy to communities to tailor program areas and focus on community needs and priorities.
- Several regions, including Saskatchewan and Alberta, have utilized a combined approach to MCH and FASD program delivery. Within Saskatchewan, combined regional program standards were developed that are inclusive of MCH Mentoring, FASD Mentoring, and FASD Community Coordination programs.
- Within the Alberta region, a strong focus on knowledge sharing, training, and capacity building was described by key informants during the evaluation timeframe. For example, quarterly regional meetings were held with First Nations representatives to support training and exchange of program experiences. Additionally, training opportunities were developed in partnership with the Public Health Agency of Canada, Alberta Health Services, and the Alberta Home Visitation Network.
- Within the Manitoba region, the MCH program is housed at the First Nations Health and Social Secretariat of Manitoba (FNHSSM), who provide program orientation, monitoring, training, and support to communities and staff to meet program standards. The *Strengthening Families* framework was developed to guide the MCH program, which is rooted in Dene, Cree, Ojibway, Oji-Cree, and Dakota cultures and each branch is intended to represent components of the program.[26]
- The Northern region collaborates directly with territorial governments and self-governing First Nations in Yukon and selected communities within the Northwest Territories. In the Northwest Territories, First Nations communities received Community Wellness

[26] FNHSSM. (n.d.). *Maternal Child Health.* https://www.fnhssm.com/maternal-child-health

Initiatives Funding to deliver a broad range of activities under each of the three clusters of the Northern Wellness Agreement (i.e., healthy children, families and communities; mental health and addictions; healthy living and disease prevention). Through the healthy children, families and communities cluster, activities such as healthy pregnancies and perinatal programming, support for new parents, after-school programming, and family-oriented gatherings and events are being offered by Nations. Common challenges to program delivery within the North include health human resource challenges (high vacancy rates, high turnover, difficulties in recruiting), lack of housing for health professionals, and high costs of service delivery. As a result, some communities face considerable barriers to implementing programs. For instance, home visitation and FASD mentors, which are considered program best practices, may not be available in communities in the North despite high need.

6.0 Key Findings: Efficiency

6.1 Status of Previous Evaluation Recommendations

Finding 10: Program documents and key informants indicated that improvements have been made following the 2014 evaluation, including improved partnership development, increased funding investments, and revised performance measures.

At the time of reporting, a previous evaluation was conducted nearly ten years ago (2014). The 2014 Evaluation identified a series of recommendations for both the HCD and Healthy Living programs as the programs were evaluated as a cluster. The table below presents the recommendations and corresponding actions undertaken by FNIHB relevant to the HCD program. In-line with the three recommendations identified in the previous evaluation, FNIHB has taken steps such as establishing partnership structures in all regions; framework development; an updated costing model; developing program standards; and revised performance measures.[27]

Key informants within ISC mostly agreed that improvements had been made following the 2014 Evaluation recommendations. For example, as it relates to recommendation #1, one regional staff member described the development of “community focus teams” assigned to each area within the region to improve partnership and coordination. With respect to the second evaluation recommendation, investments in IELCC, infrastructure, governance and capacity, and training were described as evidence of improvement; however, this occurred late in the evaluation period and therefore a fulsome understanding of impacts are not yet known. Even so, continued lack of universal access to the programs was cited as an ongoing area for improvement – despite nearly ten years elapsed since the previous evaluation.

Finally, approaches to performance measurement were reported by ISC staff as an area of consideration given priorities for increased community control, community-led identification of meaningful performance indicators, and reduced reporting burden. Reporting through the CBRT has been streamlined, however some felt that the reporting data captured does not effectively inform the efficacy of HCD (see subsection: 6.4).

[27] ISC. (2014). Evaluation of the Healthy Living and Health Child Development Program Clusters Final Report. https://www.canada.ca/en/health-canada/corporate/about-health-canada/accountability-performance-financial-reporting/evaluation-reports/evaluation-healthy-living-2010-11-2012-13-healthy-child-development-clusters-2008-09-2012-13.html#b

Table 4. 2014 Evaluation Recommendations and Corresponding Actions and Deliverables

Recommendation	Actions and Deliverables
1. Improve collaborative efforts with stakeholders, partners and other service providers that ensure sustained partnerships and program integration.	✓ FNIHB has established partnership and co-management tables in all regions as a means to strengthen collaboration, joint planning, collaboration and transparency. ✓ The Chronic Disease Prevention and Management (CDPM) frameworks were developed and completed for Inuit and First Nations. ✓ In partnership with AANDC and ESDC, a comparison chart of federal children's programming was developed for First Nations, outlining early childhood development and childcare programming.
2. Sustain efforts to support improved program and service access and quality.	✓ An updated costing model for HL/HCD programs was developed and included an examination of provincial and territorial costing models and a discussion of major cost drivers (e.g., population growth, social determinants of health) ✓ Activity standards were developed for HCD
3. Streamline and implement improved performance measurement.	✓ A HCD/Healthy Living Fact Sheet was published ✓ An updated data collection strategy for HCD was completed, which included a revised Logic Model and updated performance indicators

6.2 Demonstration of Efficiency and Economy

Finding 11: The internal program management structure, human resourcing, and financial systems are supportive for the HCD program to achieve its intended results. For example, FNIHB's focus on regionalization is supporting regions to tailor funding and support according to locally identified priorities.

ISC staff reported that the internal management structures, human resources, and financial systems are appropriate to achieving results. With respect to program management and operations, FNIHB staff at the National Office within the National Capital Region lead strategic policy development and program planning in support of the HCD program – in collaboration with FNIHB regional offices and First Nations and Inuit partners. Regionally, the FNIHB offices play a lead role in supporting communities with program delivery by working with First Nations and Inuit partners at the regional and local levels. The regional offices are also responsible for the management of funding arrangements, program performance monitoring, and information roll-ups.

Through FNIHB's focus on regionalization, ISC regional offices have a wide range of management structures and operational approaches that align with local priorities and functions. For example, in the Atlantic region, HCD programs have been grouped with the Children's Oral Health Initiative under one directorate to increase efficiency and support collaboration across programs. Uniquely, the FNIHB northern region works directly with the territorial governments

and self-governing First Nations in Yukon and selected communities within Northwest Territories. In Nunavut and the remainder of Northwest Territories, the FNIHB northern region works directly with territorial governments to negotiate funding arrangements for health programming.

According to program documents, additional areas of efficiency both internally and on a community level include the following:

- **Partnering.** The development of partnerships, particularly with provinces and regional authorities, as well as with other federal partners (e.g., ESDC) is considered by regions as the most productive and efficient way to build greater access to children services, including provincial services.

- **Clustered delivery.** In some regions, clustering of children's programs for funding and service delivery creates efficiencies and helps support increased access. For example, one staff member may deliver nutrition screening and FASD programming when meeting with pregnant women in community.

- **Community health planning.** The development of community health plans, which are tied to Block funding models, are seen as effective to facilitating the development of partnerships, building increased access to services, and improving programming quality. For example, block agreements support the ability of programs to work in clusters, allowing for better coordination and integration of CPNP, MCH and FASD services for children and families.

Frequently citing the departmental mandate for the transfer of services, ISC staff generally did not perceive a need for additional resources or personnel to support operations. However, some consideration for regional staff capacity to support communities with transition planning and program development were raised (see subsection: 9.2 - Service Transfer). An additional area of consideration identified by some ISC staff is a transition away from internally siloed program funding and towards an envelope funding approach. The evaluation did not identify specific in/efficiencies between the two funding approaches, though this may be a consideration moving forward in consultation with communities.

> *"We always say that we are a little out of step because we talk about funding by program, but we tell the communities that it no longer works by program, you are in block funding mode. And that's a bit strange to continue to fund by program and then, even us, at the financial analysis level, having lines for each of the programs, but ultimately the community is managed under block funding."*

6.3 Capacity to Achieve Intended Objectives

Finding 12: Underfunding of programs throughout the evaluation timeframe is a primary barrier to program delivery and the achievement of outcomes. This has a downstream impact on human resourcing and limits the "reach" of programming.

Across all lines of evidence, the evaluation consistently found that there are considerable capacity constraints (i.e., financial resources, human resource shortages, training) impacting the effective delivery of programs in community.

As previously mentioned, funding throughout the evaluation timeframe has largely remained stagnant despite changing program contexts driven by population growth, inflationary pressures, and more complex needs reported in community. Both interview participants and survey respondents described a changing context of program delivery, as some communities are facing complex challenges associated with substance use, violence, poverty, and food insecurity. According to the survey, less than 30% of respondents agreed or strongly agreed that funding meets the needs of community, that funding is flexible enough, or that funding comes at the right time to plan and deliver programs (Figure 3). For example, one respondent commented: "Our programs have been underfunded for at least 20 years, the funding top ups help a considerable amount, but it will take years to catch up and get up to a standard before we can start to close the gaps that have been created for years."

Similarly, both community-based respondents and ISC staff spoke to the detrimental impacts of underfunding - communities are forced to prioritize families and children with the highest needs; children are "falling through the cracks"; and innovative programming which incorporates promising practices is limited.

A number of strategies were described by community representatives to maximize funding, including sharing facilities (e.g., day care and head start; community centre), pooling resources across programs (e.g., across HCD or utilizing Jordan's Principle funding), collaborating with staff to deliver programs (e.g., community health nurse, dietitians), and leveraging other resources where possible (e.g., provincial funding). However, it was consistently emphasized that additional funding is needed to achieve impact in-line with program goals.

The funding allocated is not enough, especially with the cost of living going up each day. We are managing, but even to have some sort of programming is hard, it is split right now so doing the full program is difficult. To get someone in that position that wants to work for that amount of money and with that many children is hard.

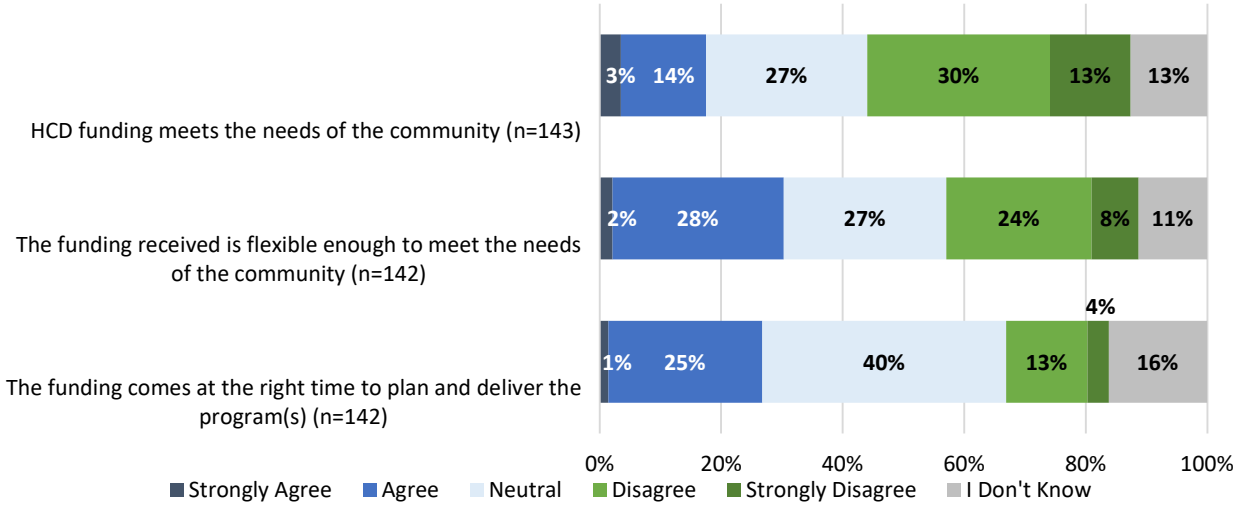


Figure 3. Level of agreement with the funding conditions of HCD programming (n=142-143)

As noted elsewhere (see subsection: 5.1), the absence of appropriate funding also impacts the ability of communities to recruit qualified staff and retain staff over time due to low wages and high demands placed on staff (e.g., managing several programs, high case loads, lack of administrative support). In turn, program innovation is limited as communities are unable to engage in long-term planning and historical program knowledge and experience is lost. The evaluation found that these challenges may be more acutely felt among remote and isolated communities due to overall higher costs for program delivery, limited infrastructure and housing available, and high caseloads placed on few staff. With these considerations in mind, some contributors suggested that funding formulas must be revisited to ensure funding is relevant to true population size/growth, growing needs/complexity, and context (i.e., for remote communities and in the North).

6.4 Performance Measurement

Finding 13: There are limitations to the use and design of the CBRT. The evaluation identified opportunities to enhance performance measurement approaches that align with First Nations priorities and support program improvement. For example, narrative-based data collection can provide rich detail on program delivery.

The HCD program relies on several data sources to inform program performance, including the CBRT, an Annual Training Reporting Template, the Regional Health Survey (First Nations Information Governance Centre), the Canadian Birth Census (Statistics Canada), and the National Dental Database and Manitoba Dental Database.

Key informants primarily offered feedback about the relevance and usefulness of the CBRT. As previously stated, the CBRT is a reporting requirement associated with certain contribution agreements between First Nation communities and FNIHB. Resultantly, the CBRT does not represent all communities that deliver a particular program as it only captures data from communities in “lower capacity” agreements. As a result, this has led to an informational gap concerning program delivery and impact in higher capacity communities. Key informants emphasized that while relaxed reporting requirements align with departmental commitments, the data and impact-driven nature of central agencies within government creates challenges to

illustrating performance as program impact data may be limited, unavailable (e.g., if between cycles of the RHS), and/or gathered anecdotally.

Key informants also saw opportunities to improve the data gathered through the CBRT. For example, it was noted that a focus on "counting widgets" may not be informative as it primarily captures output-oriented program data. Additionally, privileging western-based quantitative measures may not align with First Nations perspectives and priorities for communicating program impact. One key informant stated: "Often one of the biggest perils in capturing data in a quantitative matter is that qualitative data is lost - the stories, best practices, pictures of events." Increasing opportunities for narrative-based reporting may provide a more fulsome picture of the program story in community. Indeed, an article by the International Journal of Indigenous Health notes that privileging western-based indicators to measure health and well-being of First Nations people do not align with Indigenous worldviews on health, including spirit, ceremony, connection to land, and culture and identity. Among promising practices to the development of appropriate First Nations indicators and reporting, indicators must be culturally relevant and centered on First Nations worldviews on health and wellness; honour Indigenous knowledges and approaches; be grounded in relationship-building and meaningful engagement; self-determined by Indigenous leadership; and strengths-based while contextualizing indicators within the broader historical, social, and political realities that influence First Nations well-being.[28]

From the perspective of communities, representatives were mostly neutral about the reporting process; more specifically, approximately half of survey respondents felt neutral about the reporting requirements from ISC, whereas a roughly equal share of respondents rated the requirements as easy (18% rated the requirements as 'easy' or 'very easy') or difficult (19% reported as 'difficult' or 'very difficult') (n=131). Some indicated that reporting mechanisms such as the CBRT were useful to track program activities over time, and some felt that the contents had improved (i.e., information is more streamlined and less burdensome). However, some indicated that the reporting criteria is misaligned and difficult to adapt to their programs, and frequent changes to the reporting requirements over time has created challenges to longitudinally track program metrics and adapt reporting systems. Additionally, frequent turnover within some ISC regions has led to frustration among communities as reporting is subsequently lost.

"Some programs run from September to June; I have had a very hard time answering questions to fit our program, as we are reporting on two different groups of children and their families."

"I would say that there should be a place [in the CBRT] to put NEEDS in the community and how can [ISC] serve you best."

"The CBRT is challenging when you have different programs that need to report. Sometimes it makes you wonder if it is relevant collection of information."

Fulfilling reporting requirements could be improved with greater access to reporting guidance (e.g., for new staff), more advanced notice of content changes, and more clarity regarding how the reporting information is used. The program could also consider the inclusion of text-based

[28] Stelkia, K., Manshadi, A., Adams, E., Wieman, C., & Reading, J. (2023). Weaving Promising Practices to Transform Indigenous Population Health and Wellness Reporting by Indigenizing Indicators in First Nations Health. *International Journal of Indigenous Health*, *18*(1).

responses in annual reporting to allow representatives to qualitatively reflect on program delivery, strengths and accomplishments, and support needs.

7.0 Key Findings: Sub-programs

7.1 Aboriginal Head Start On Reserve

Finding 14: The AHSOR program is supporting the development of a positive cultural identity, improved school readiness, and greater achievement of emotional and developmental milestones. However, the capacity to deliver effective programming is limited by poor infrastructure and stagnant funding against community changes (e.g., population growth, increasing needs).

The evaluation found that AHSOR programs are operating with a holistic approach to supporting child development – including integration of Nation-based culture and language activities, play-based learning, health promotion, nutritious food access, and involvement of parents. Additionally, programs are integrating practices such as land-based learning and involvement of Elders in program delivery. The key accomplishments within the AHSOR program as described by community representatives include strengthened connection to culture and positive identity, improved school readiness, the development of trusting relationships with children and families, and achievement of emotional and developmental milestones. Key informants often emphasized that AHSOR programming is highly important to community, having been established for many years.

The positive impacts of AHSOR programming have also been reported through the Regional Health Survey (RHS) and the First Nations Regional Early Childhood, Education, and Employment Survey (FNREEES). To illustrate, Phase 3 of the RHS found that a higher percentage of children who attended AHSOR had knowledge of a First Nations language (76.9%), compared to children who had not attended the program (61.2%). Additionally, the survey found that children attending AHSOR were more likely to participate in community cultural events, engage in weekly traditional activities outside of school hours, and consume traditional foods.[29] The FNREES also found that 73.3% of primary caregivers with children (under the age of 6) attending a First Nations–specific early childhood program (like an Aboriginal Head Start On Reserve Program) reported that their children understood them when they spoke all of the time, compared to 57.5% of children who did not attend a First Nations–specific early childhood program.[30]

While AHSOR programs have demonstrably contributed to positive outcomes for children and families, several challenges to effective program delivery were also noted. Frequently, survey and community-based respondents reported infrastructure and facility concerns due to lack of space, inadequate or unsafe outdoor access, outdated facilities, and overdue repairs and renovations. For example, one survey respondent commented: “the facilities available for HCD are not child-safe/proof, they are small and outdated, and there is no location where materials can be safely stored without requiring having to transport everything needed for programming

[29] First Nations Information Governance Centre. (2018). National Report of the First Nations Regional Health Survey Phase 3: Volume Two, (Ottawa: 2018). https://fnigc.ca/wp-content/uploads/2020/09/53b9881f96fc02e9352f7cc8b0914d7a_FNIGC_RHS-Phase-3-Volume-Two_EN_FINAL_Screen.pdf

[30] First Nations Information Governance Centre. (2016). Our Data, Our Stories, Our Future: The National Report of the First Nations Regional Early Childhood, Education and Employment Survey, (Ottawa). https://fnigc.ca/wp-content/uploads/2020/09/fnigc_fnreees_national_report_2016_en_final.pdf

(requiring a vehicle, space and time)." Often, staff reported collaborating with community daycare programming to share costs and program space.

Additionally, program staff noted that funding has not increased or kept pace with population growth and changing needs/priorities. Specifically, some communities reported an increase in support needs among some children entering AHSOR – including behavioural challenges, developmental delays, and children requiring speech and language support. Efforts have been made by staff to access further training and integrate supports for children, however the high demands on program staff and long wait times to access specialized services (e.g., speech language pathology, occupational therapy, etc.) are creating challenges within the program and more broadly among communities. Inadequate funding has also created challenges for retaining qualified staff due to low wages and limited opportunity for salary growth.

7.2 Maternal Child Health Program

Finding 15: The MCH program is often delivered collaboratively and serves as a vital link to other supportive services available in community. Capacity challenges (i.e., one staff responsible for high caseloads and/or multiple programs), inadequate funding, and incommensurate skill sets against more complex client needs are key factors constraining the program.

As previously mentioned, the evaluation found that the MCH program is often delivered in collaboration with other programs/staff (i.e., FASD, CPNP workers, dietitian, community nurse) to support more comprehensive programming for families and overcome funding gaps. Therefore, findings specific to the MCH program area were not always clearly delineated. With that being said, the evaluation found that the MCH program often operates as an important link between women/families and the broader network of supports and services. Activities conducted by MCH workers included developing meal and supply packages, hosting workshops and group activities (e.g., breastfeeding circle, moss bags, ribbon skirts, star blankets, meal preparation), conducting home visits, transporting clients (e.g., grocery shopping, appointments), and referring caregivers and families to other services (e.g., paediatrician, dietitian).

According to survey participants, the MCH program is achieving the greatest impact in providing support to families and children up to age 6 (89% strongly agreed or agreed) and in promoting healthy pregnancies (86% strongly agreed or agreed). A lower proportion of respondents agreed that MCH had led to increased culturally relevant training opportunities (70%), greater First Nations control over the planning and delivery of services (71%), or increased coordination of services (71%). Qualitatively, ISC and community-based staff reported that the MCH program helps to "bring people together," build trusting and supportive relationships, and encourage goal setting for parents and families.

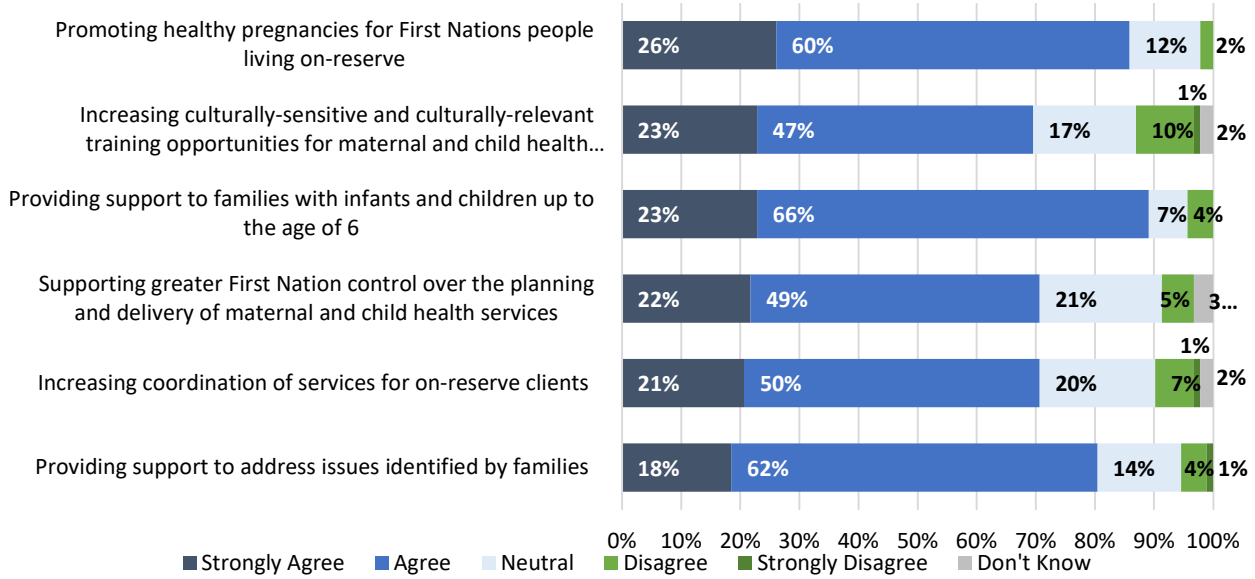


Figure 4. Level of agreement with the achievement of MCH Program-level outcomes among respondents involved with the MCH Program (n=92)

Community engagements and findings from the survey indicate that the needs often overwhelm the MCH program. In some Nations, the complexity of needs has evolved and greater rates of substance use, food and income insecurity, and violence are reported. At the same time, MCH staff are constrained by capacity challenges, inadequate funding, and incommensurate skill sets to address these needs. Additionally, some Nations reported that population sizes have increased and exceed the capacity of the program. In some regions (i.e., Northern region), the MCH home visitation model was reported as entirely unavailable due to inadequate funding, despite being considered a best practice of the program.

> *"[Program funding] goes to salary. There are no dollars for the programming. They need to put in more money in to support salaries. We end up partnering up with other programs to save funding and piggyback off each other. We shouldn't be operating like that, it's short-changing each program."*

With additional funding, community-based representatives described an interest in accessing culturally relevant training to deliver education and awareness on traditional childbirth and parenting practices. Additionally, staff reported a need for enhanced training to better address the needs of people who use substances while maintaining the safety of home visitors.

7.3 Fetal Alcohol Spectrum Disorder Program

Finding 16: The FASD program is primarily functioning to build awareness and education through community events due to small program budgets. Challenges encountered within the program include difficulty providing case management and ongoing stigma around FASD. Additionally, limited access to diagnostic services is a key barrier to effectively meeting the needs of children with FASD.

Due to limited funding, communities often reported "delivering" the FASD program through one-off events (e.g., awareness day, health fair) with a primary focus on education and awareness.

Findings from the community-based survey indicate that FASD program is most successful in building trusting relationships with people at risk of drinking while pregnant (72% strongly agreed or agreed), whereas respondents were in less agreement that the program is building community capacity to address and prevent FASD (61% strongly agreed or agreed) or supporting case management of children with FASD (41% strongly agreed or agreed). This was corroborated by community-based representatives, who identified case management and limited access to diagnostic services (e.g., long wait times) and specialized supports as a key challenge to effectively meeting the needs of people with FASD and/or people who consume substances while pregnant. As one regional staff member noted:

> Putting individuals at center of services is very difficult when the boundaries of the services sit outside of the control of health centre providers. The funding communities receive under FASD is to provide health promotion and education, but diagnostic services and associated supports/resources lie often at a provincial level of jurisdiction.

Jordan's Principle was noted by some community-based staff as an avenue to support children requiring assessments (e.g., for children with autism, FASD, or ADHD). However, long wait times were again reported as a barrier to connecting children and families with the appropriate resources.

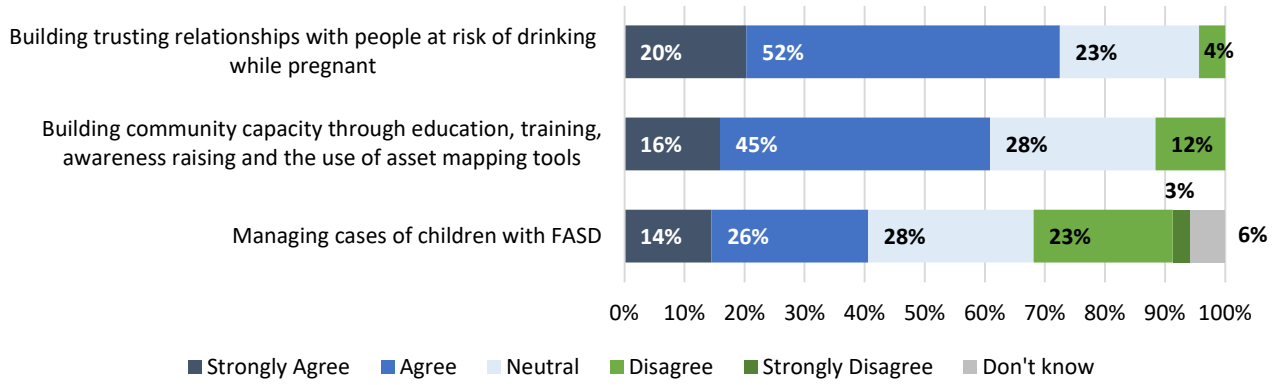


Figure 5. Level of agreement with the achievement of FASD Program-level outcomes among survey respondents involved with the FASD Program (n=69)

An additional factor impacting program delivery as noted by ISC staff and community representatives is the ongoing stigma surrounding FASD and disclosure of alcohol use. In particular, a parent may avoid accessing services/supports due to fear of involvement of child welfare services. Accordingly, communities reported using strategies such as renaming the program to be more strengths-based (e.g., "wellness" program) and focusing on resilience and goal setting. With additional program funding, community-based staff expressed an interest in offering expanded programming such as family summer camps focused on FASD awareness.

7.4 Canada Prenatal Nutrition Program

Finding 17: The CPNP is successful in increasing access to nutritious foods, building skills, and improving the diets of prenatal and breastfeeding First Nations women. However, the scope of programming is increasingly limited as program budgets have not increased against rising food and supply costs.

Activities delivered through CPNP include prenatal classes, breastfeeding support groups, cooking education, infant food preparation, and the provision of food vouchers. Additionally, some communities are involving doulas to deliver the CPNP using an expanded approach, focused more broadly on prenatal support.

Findings from the community-based survey suggest that CPNP is most successful in increasing access to nutrition and lifestyle counselling (86% strongly agreed or agreed) and improving the diet of prenatal and breastfeeding First Nations women (85% strongly agreed or agreed). CPNP was also reported by most to be successful in increasing access to referrals (74% strongly agreed or agreed) and increasing breastfeeding education and support (74% strongly agreed or agreed). Qualitatively, evaluation contributors also noted the importance of CPNP in increasing access to nutritious food and empowering women and families through skill-building activities.

As an example, in one region, CPNP coordinators co-developed an infant feeding resource guide alongside women in several First Nations communities. The resource guide utilizes a storytelling approach and is intended to support a path of healthy eating based on best practices while maintaining a pragmatic understanding of the wide range of experiences of women as it relates to infant feeding.

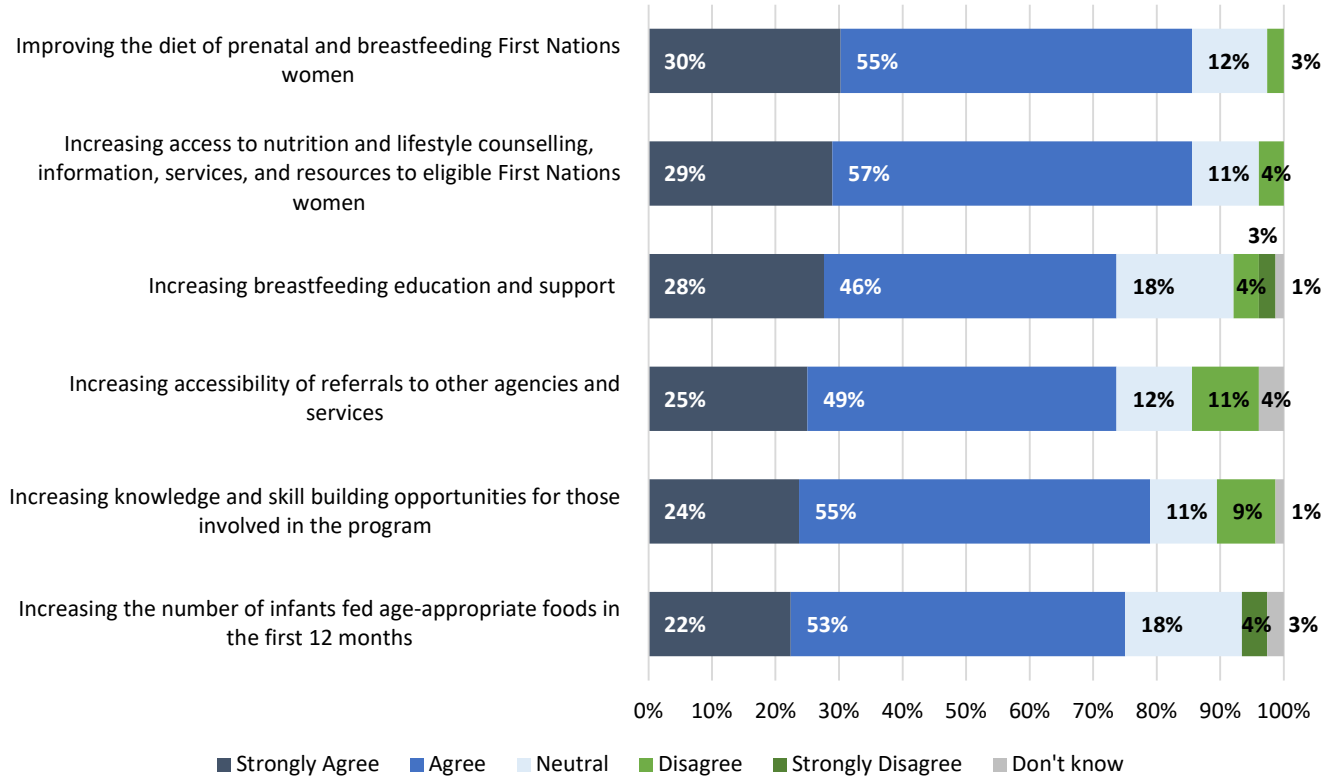


Figure 6. Level of agreement with the achievement of CPNP Program-level outcomes among survey respondents involved with the CPNP Program (n=76)

A primary challenge reported by regional staff, community engagements, and survey respondents is the rising cost of food prices and lack of increase in programming investments, which has greatly limited the scope of programming. As a result, one staff member may be responsible for CPNP alongside several other programs/services. Rising costs have also impacted communities overall, leading to higher rates of food insecurity and increased demand on the program. One survey respondent stated:

> *"The increase cost of formula and even nutritious foods can affect a healthy diet. Providing programs on making your own baby food still requires families to purchase these healthy foods."*

8.0 Summary of Wise Practices & Lessons Learned

Finding 18: Overall, a wide range of distinctive practices and strengths were mentioned, such as offering regular community engagement opportunities to co-identify program activities and priorities, collaborating with other partners in community to holistically serve families, and grounding culture-based practices, ways of knowing, language, and ceremonies into programs.

General Guiding Principles

The rich diversity across First Nations ways of knowing and being, cultural and traditional practices, histories, and geographic and economic contexts reiterates: 1) the lack of a single "best practice" in delivering programs, 2) the relevance of First Nations control over the design and implementation of HCD. Community representatives engaged through in-person visits and the survey described a wide range of approaches and practices to implement programming.

Commonly, some wise practices included the following:

- Regularly consulting community to identify local priorities and interests in programing (e.g., surveys, sharing circles, or other mechanisms)
- Offering land-based education and activities (e.g., family summer camps, community gardens)
- Collaborating with partners in community to support wraparound care and services for families, including through combining the MCH, FASD, and/or CPNP programs to provide a comprehensive health promotion intervention
- Grounding culture, language, and Nation-based ways of knowing as the foundation of programming (e.g., traditional parenting and childbirth education classes)
- Bringing parents and community members together through group programs and activities (e.g., breastfeeding support circle, ribbon skirt making, father's circles)
- Regularly involving Elders to instruct and support programs

Regional and Program Highlights

To support integrated program delivery and centre traditional birth and childcare practices, some Nations reported combining the MCH and CPNP program and involving a doula or other traditional birth support worker to deliver the program activities through a holistic lens.

In one First Nation, the community AHSOR program has collaborated closely with an Indigenous Speech Language Pathologist (SLP) to create an Indigenous approach to speech and language education. Incorporating teachings from the Medicine Wheel and the stages of life, this approach has departed from conventional assessment methods like the Ages and Stages Questionnaire and recreates the SLP assessment to be family-centered and supportive rather than deficit-based. Additionally, a Nation-based Jordan's Principle speech and language summer camp was created, which interweaves cultural elements and land-based activities. Ceremony is also being offered in the Nation's AHSOR program based on the direction of Elders.

In another Nation, a strong partnership has been formed with an urban organization specializing in services for children and families. These services encompass crisis childcare, short-term shelter, parental guidance, screening and assessment, as well as developmental assistance – with an emphasis on keeping children and families together and preventing involvement of the Ministry care system. This collaboration follows a reciprocal learning model, where the urban organization's expertise has supported the development of on-reserve programming, while the Nation's input has tailored urban services to Indigenous families' unique needs. One noteworthy outcome of this partnership includes a process to administer the Ages and Stages Questionnaire with an Indigenous lens, mitigating the potential misclassification of children as developmentally delayed. This collaborative partnership is also resulting in more comprehensive support for families transitioning between the city and the reserve, offering a seamless continuum of care and services.

In the Atlantic region, through Health Partnership processes, FNIHB and the Atlantic First Nations jointly developed the Child and Youth Strategic Action Plan 2013-2018 to commit to a path of targeted health investments for children and youth. The Action Plan identified five strategic directions for upstream investments and several achievements were realized following the plan's implementation. For example, one First Nation has achieved high success in FASD and MCH program activities through focusing on an integrated approach to program delivery, such as by offering community baby fairs, talking circles, young mom's cooking classes, after school youth volunteering, movie nights, and nature walks; all gatherings are focused on health themes related to FASD and MCH. Additionally, through the work of nine FASD coordinators and five MCH coordinators, connections and referrals are made with other partners (e.g., community health centers, drug and alcohol program workers, AHSOR, and provincial service partners) to share knowledge and resources and avoid duplication.[31]

9.0 Cross Cutting Themes

9.1 Climate Change

Finding 19: The primary impacts of climate change as it relates to the HCD program include limited/reduced access to materials and supplies, disruptions to land-based programming,

[31] Atlantic First Nations. (2020). *Atlantic First Nations Child and Youth Strategic Action Plan 2013-2018.* https://www.apcfnc.ca/wp-content/uploads/2020/07/Child_and_Youth_Strategic_Action_Plan_Final_Report_2013-2018.pdf

decreased access to traditional food systems, and poor infrastructure. The impacts of climate change may disproportionately impact remote and isolated communities.

Findings from the literature suggest that the effects of climate change have a disproportionate burden on some groups, including First Nations women and children, and people in remote and isolated communities.[32] Generally, respondents did not indicate that climate change had directly or significantly impact programming. Approximately half of survey respondents (54%) reported feeling neutral about the impacts of climate change on program delivery, 17% strongly agreed or agreed, and 25% disagreed or strongly disagreed that they had observed impacts (n=153 overall).

The primary considerations as identified by regional staff, community representatives, and survey respondents are as follows:

- Materials, food, and supply access is threatened due to shortening of ice road access as seasonal temperatures increase;
- Due to an increase in air quality advisories and heat waves, opportunities for land-based and outdoor learning (e.g., through AHSOR programs) are constrained;
- Disruptions to animal migration patterns and decreased access to traditional foods are impacting food security and have downstream impacts on community well-being;
- As extreme weather events are more frequent, inadequate infrastructure to withstand weather events and allow for safe sheltering are a concern

9.2 Service Transfer

Finding 20: Promising practices to advance self-determination have been identified, including clearly defined roles and responsibilities, scalable funding approaches with adequate resourcing, advisory/technical support, and workforce development. Efforts to work towards service transfer is evidenced by a gradual and overall trend in communities moving to more flexible arrangements and improved partnership structures across the regions. However, adequate and stable funding is an important constraint.

According to the literature, governance models which advance self-determination and improve outcomes for communities are defined by elements such as:

- clearly articulated roles and responsibilities between all jurisdictions in health governance (e.g., federal, provincial/territorial, Indigenous governments);
- “scalable” models of self-determination based on community capacity;
- adequate, sustainable, and flexible funding arrangements that are relevant to local needs and enable long-term planning and integrated approaches;
- ongoing government support in the form of human, physical, and financial resources;
- appropriate workforce development, recruitment, and retention; and

National Collaborating Centre for Indigenous Health. (2022). Climate Change and Indigenous Peoples’ Health in Canada. https://www.nccih.ca/Publications/Lists/Publications/Attachments/10367/Climate_Change_and_Indigenous_Peoples_Health_EN_Web_2022-03-22.pdf

- delivery of programs/services that are defined by Indigenous ways of knowing with a focus on holistic approaches.[33]

Respondents from ISC and on a community level noted that some progress has been made in supporting the return of control over services, as indicated by a gradual and overall trend in communities moving to more flexible arrangements and the development of partnership tables and co-management structures to foster First Nations decision making. Additionally, one region reported recently establishing a program specialists committee, which brings together all specialists across programs within the CBRT. With the goal of moving communities into more flexible arrangements, the committee reviews budgets and work plans and provides guidance to communities as needed.

Some regional examples of transferred service oversight were identified. Within the Manitoba region, the MCH program has been transferred to the First Nations Health and Social Secretariat of Manitoba (FNHSSM), who are responsible for program orientation, monitoring, training, and support to communities and staff to meet program standards. Similarly, the regional FASD program, referred to as Success Through Advocacy and Role Modelling (STAR) in Manitoba, is housed at the South East Resource Development Council, where all program orientation, monitoring, and training is carried out. Additionally, one of the key factors which make delivery within the Quebec region unique is the existing transfer of the Canada Prenatal Nutrition Program directly to communities. As a result, contribution agreement holders do not have reporting requirements or other follow-up obligations to their funding arrangement for CPNP.

Overall, community capacity building was frequently emphasized as an area of priority and opportunity. According to community respondents, the following are among factors which can increase readiness for service transfer:

- access to training and mentorship programs, knowledge sharing and peer-based learning opportunities;
- appropriate transition planning in collaboration with ISC;
- administrative and program planning support (e.g., work plan development, budgeting, etc.)

Furthermore, ongoing deficiencies in funding cannot be understated as an important factor limiting the transfer of control – as it impedes capacity building and long-term planning, recruitment and retention of qualified staff, and access to necessary training.

Some regional staff identified internal capacity constraints as a risk to supporting service transfer. Specifically, as more First Nations are entering self-governance agreements, HR support is required from FNIHB in the form of program planning and development, goal setting and identification of outcomes, budgeting, and other administrative assistance.

9.3 Early Impacts of COVID-19

Finding 21: COVID-19 significantly impacted HCD program delivery due to community lockdowns and changing priorities. A key lesson learned from the pandemic is the importance of

[33] Halseth, R. & Murdock, L. (2020). "Supporting Indigenous Self-Determination in Health: Lessons Learned from a review of Best Practices in Health Governance in Canada and Internationally." *National Collaborating Centre for Indigenous Health.* *https://www.nccih.ca/Publications/Lists/Publications/Attachments/317/Ind-Self-Determine-Halseth-Murdoch-EN-web-2020-12-02.pdf*

supporting First Nations to exercise self-determination in responding to emerging needs and priorities. Following the pandemic, an increase in needs among children and families have been reported.

The evaluation found that the COVID-19 pandemic had a considerable impact on the HCD programs and, in many cases, has exacerbated needs in community.

With respect to the delivery of programs, regional staff and communities reported that programs were not operational or were greatly limited in scope due to a variety of factors, including public health restrictions, redeployment of staff to address other priorities (e.g., safety, vaccinations, screening), staffing challenges (e.g., burnout and retention), and poor technology and connectivity infrastructure. To mitigate the impacts of the pandemic, many programs pivoted to online activities to support children and families (e.g., online workshops), prepared meal/supply hampers for drop-off (e.g., groceries, activities, diapers, infant formula), and/or offered outdoor "porch visits" or text/phone services to connect with community members. Community representatives noted that re-engaging children and families in programming since the height of the pandemic has been difficult.

Additionally, the evaluation found that the COVID-19 pandemic has had a ripple effect on the well-being of communities. Many community-based staff, survey respondents, and regional staff spoke to new/emerging challenges as a result of stress, isolation, grief and loss, and economic precarity. This included increased or more complex substance use, violence, food insecurity and poor access to the social determinants of health, reduced mental wellness, and heightened developmental delays and behavioural challenges among children. The implications of the pandemic for children, in particular, was highlighted as a significant area of concern to staff and one which required greater resources to effectively address going forward.

Reflections from community representatives and ISC staff reiterate the importance of supporting Nations to design, deliver, and adapt programming that best align with local priorities, needs, and constraints. For instance, some communities reported success with transitioning to online programming (e.g., virtual circles, workshops) and indicated continuing to offer some virtual activities to reach families that may not be engaged otherwise. In other cases, re-allocating program funds to provide supply packages was deemed necessary to address rising food and economic insecurity.

10.0 Conclusions

Ultimately, the evaluation found that there is a demonstrated need for HCD programming to address health and social disparities and support a positive trajectory for children and families. While the needs of First Nations children and families vary across communities, key overarching priorities facing First Nations include food insecurity and access to traditional food systems, inequitable experiences of chronic disease, and disparities in pregnancy and birth outcomes. Furthermore, as the needs experienced among children and families are reported to have risen in acuity and complexity, continued investment in programming alongside a focus on the social determinants of health must be a priority.

With respect to program performance, communities have reported positive impacts because of HCD funding. For example, communities showcased innovative and community-based interventions focused on increasing access to the necessary resources for well-being, building life skills, strengthening connection to culture and language, promoting healing, and preventing further harm through early intervention. Increased investment in some of the program areas through Budget 2017 has supported improvement in program access and quality – however, as this was near the end of the evaluation timeframe, a fulsome understanding of impacts is not yet known. While the program's performance measurement strategy was revised following the 2014 Evaluation, limited access to program performance data to assess the achievement of outcomes was a limitation encountered during the evaluation.

The evaluation found that the HCD programs are collaborating effectively in community. Often, community-based staff were fulfilling multiple program "roles" and delivering activities which combine program areas (e.g., MCH and FASD delivered as a combined home visiting program). On a sub-program level, the key strengths of the AHSOR program are: strengthening connection to culture and language, improving school readiness, and supporting the achievement of emotional and developmental milestones. The MCH program is supporting women to access necessary resources and supplies, facilitating linkages with other services, and supporting goal-setting through trusting relationships. The FASD program is functioning to build awareness and education within the community and develop trusting relationships with people at risk of drinking. Lastly, the strengths of the CPNP include its emphasis on increasing access to nutritious foods and supporting skill development. However, across all sub-programs, lack of adequate funding was a core concern (outlined below).

The evaluation identified several ongoing constraints to program performance. Most notably, lack of adequate, long-term funding is a significant barrier to achieving impact overall and within sub-programs. Funding was largely stagnant through the evaluation timeframe; at the same time, communities experienced population growth, increasing costs tied to inflation, and higher needs among children and families (driven by factors including food insecurity, violence, more complex substance use, and grief and trauma). Within the programs, inadequate funding has led to difficulty recruiting and retaining qualified staff, overburdening of staff (i.e., one staff fulfilling multiple roles), and ultimately limited the scope of program delivery. This has also impacted the extent to which communities can integrate traditional activities into programming and effectively reach all children and families. Lack of access to adequate, stable, and long-term funding to build community capacity and support long-term planning is also a threat to the departmental mandate for advancing the return of control over services.

The lack of universal program coverage was identified as a service gap within the programs. Some regions have "universally" funded communities (though funding is not sufficient), whereas others have utilized a targeted approach to funding, leading to gaps in access. Additionally, the evaluation found that while the programs are primarily focused on children, there appears to be

a gap in services for youth. This may be due to several factors, including historical program parameters restricting the age range of programming (i.e., 0-6) and lack of awareness among communities, and lack of funding available to expand programs to all children and youth in the community.

Finally, the evaluation found that COVID-19 had a considerable impact on programming as planned activities were halted or significantly limited and community-based staff were redeployed. Some climate change related considerations were also identified, including the impacts of reduced road access and supply challenges, disruptions to land-based programming, and food security impacts associated with environmental degradation.

11.0 Recommendations

Based on the findings from the evaluation, it is recommended that ISC:

1. Identify mechanisms to improve program access, including through improved understanding of program needs, and identification of partnership opportunities /and other mechanisms for increased and sustained program resources.

Access to high quality, culturally appropriate early childhood development programming remains a priority for First Nations to address inequitable outcomes, support a foundation of well-being, and encourage a positive trajectory of good health (Finding 1, 2). The evaluation found that overall lack of universal access to programming remains an ongoing concern (Finding 5, 7). It is worth nothing that while some regions are funding through a universal approach, historic underfunding is a significant barrier to program reach and impact. With insufficient funding allocations, regions are required to choose between basic service access (i.e., by funding all communities with a small share of program dollars) or funding enhanced programming in select Nations (i.e., by funding some but not all). Additionally, on a Nation or community level, the available funding does not permit community-based staff to reach all population groups - particularly, prevention programming for children/youth above age 6, despite being a high priority.

As such, it is recommended that ISC identify mechanisms to increase program access through sustained program investments and identification of relevant partnerships where possible to ensure communities are adequately resourced to deliver high-quality services that meet the needs of children and families.

2. Identify concrete opportunities and mechanisms to support knowledge sharing across the HCD workforce and within sub-program areas to foster capacity building and facilitate diffusion of wise practices and lessons learned.

Communities engaged in the evaluation consistently identified an interest in knowledge sharing and partnership development opportunities to foster innovation, build overall capacity, and share program experiences (Finding 4, 20). Additionally, as many described the needs among clients as more complex in nature, ensuring there are mechanisms to access appropriate training, reflect, debrief, and exchange promising practices and lessons learned is important to supporting workforce wellness and capacity.

It is recommended that ISC explore opportunities for knowledge exchange across communities, such as by leveraging virtual mechanisms (e.g., communities of practice) and/or through in-person regional gatherings.

3. Regionally, increase partnership and relationship building efforts with communities (among those who desire) through regular communication, information sharing, and relationship building to support effective program delivery, co-identify solutions/opportunities, and build community capacity.

Communities frequently expressed a desire for more direct communication and engagement with regional ISC staff (Finding 8, 20). Dependent on the community's desire for involvement - this could include consistent information sharing to build understanding about the program (e.g., for new staff), regular updates on funding and any programming changes (e.g., as it relates to

reporting), and helping to showcase promising practices and innovative activities occurring across communities, while also being available to provide technical support where requested. Additionally, requests for more in-person engagement and partnership development (i.e., visits to community) were emphasized among communities engaged in the evaluation – particularly following COVID-19.

More frequent interactions would support continued awareness of the program, facilitate linkages with other program teams or resources available, contribute to capacity building , and build understanding of emerging needs, program realities, and constraints. As communities have varying interests and preferences for the level of engagement with ISC, regional consultations with communities could inform which approaches to engagement and partnership building may be most appropriate/preferred.

4. Alongside First Nations partners, explore opportunities to revise and innovate performance measurement approaches, built upon appropriate data sources, to improve assessment of program impact, and which aligns with First Nations approaches, while maintaining a focus on reduced reporting burden.

The evaluation found that while the program has worked to streamline reporting data and reduce burden, there are ongoing gaps in program impact data as the data may be unavailable (e.g., between RHS survey cycles), does not reflect all community contexts, and reporting metrics may not align with First Nations perspectives and approaches to understanding program impacts and successes (Finding 13). However, there is an ongoing need to demonstrate program relevance and impact.

Therefore, it is recommended that the program identify opportunities to improve data gathering processes in collaboration with First Nations partners, with a focus on aligning indicators and approaches to First Nations worldviews, supporting capacity building, and maintaining self-determination. For example, increasing opportunities for narrative-based reporting may provide a more fulsome picture of program stories.

Appendix A: Evaluation Issues and Questions

The evaluation questions aimed to address issues of relevance and performance in alignment with the Treasury Board *Policy on Results*. The questions were also designed to assess the different elements and intended outcomes of the HCD sub-programs; highlight lessons learned and promising practices; and capture the lenses of climate change, COVID-19, and the journey towards service transfer and transformation.

I. Relevance: Alignment of Design with Desired Outcomes

1. Is there a continued need for the HCD cluster, including its programs and range of available services?
2. What are the current and ongoing health and social issues contributing to the need for this cluster, including its programs? How have these needs changed since the last evaluation period?
3. Does the HCD cluster duplicate or overlap with other programs, policies, and initiatives at the federal level?

II. Effectiveness: Achievement of Outcomes

4. To what extent has the HCD cluster achieved the expected outcomes at the immediate and intermediate outcome levels of its logic model?
5. To what extent have the specific programs of the HCD cluster been effective in delivering their intended support?
6. Are there service gaps with the HCD cluster, and if so, how do these gaps effect funding recipients and clients?
7. Are funding recipients and clients sufficiently aware of the resources and supports available to them to access/deliver the HCD cluster?
8. What is the level of interconnectivity/collaboration within the HCD cluster in terms of program delivery? (e.g., between regional offices and national office, between communities and regional offices, and within communities)
9. What are the regional differences in the delivery of the HCD cluster of programs?

III. Efficiency and Economy: Resource Utilization in Relation to Outputs and Progress

10. What is the status of the recommendations made within the previous evaluation of the HCD cluster
11. Has the HCD cluster been managed and carried out efficiently and economically?
12. Is there sufficient capacity (Human Resources, training, and financial resources) within the HCD cluster to achieve its intended objectives and results?
13. Are there appropriate performance measurement systems in place to track the progress of the HCD cluster?

IV. Lessons Learned: Considerations for the Future

14. Within the HCD cluster, have best or wise practices been identified?

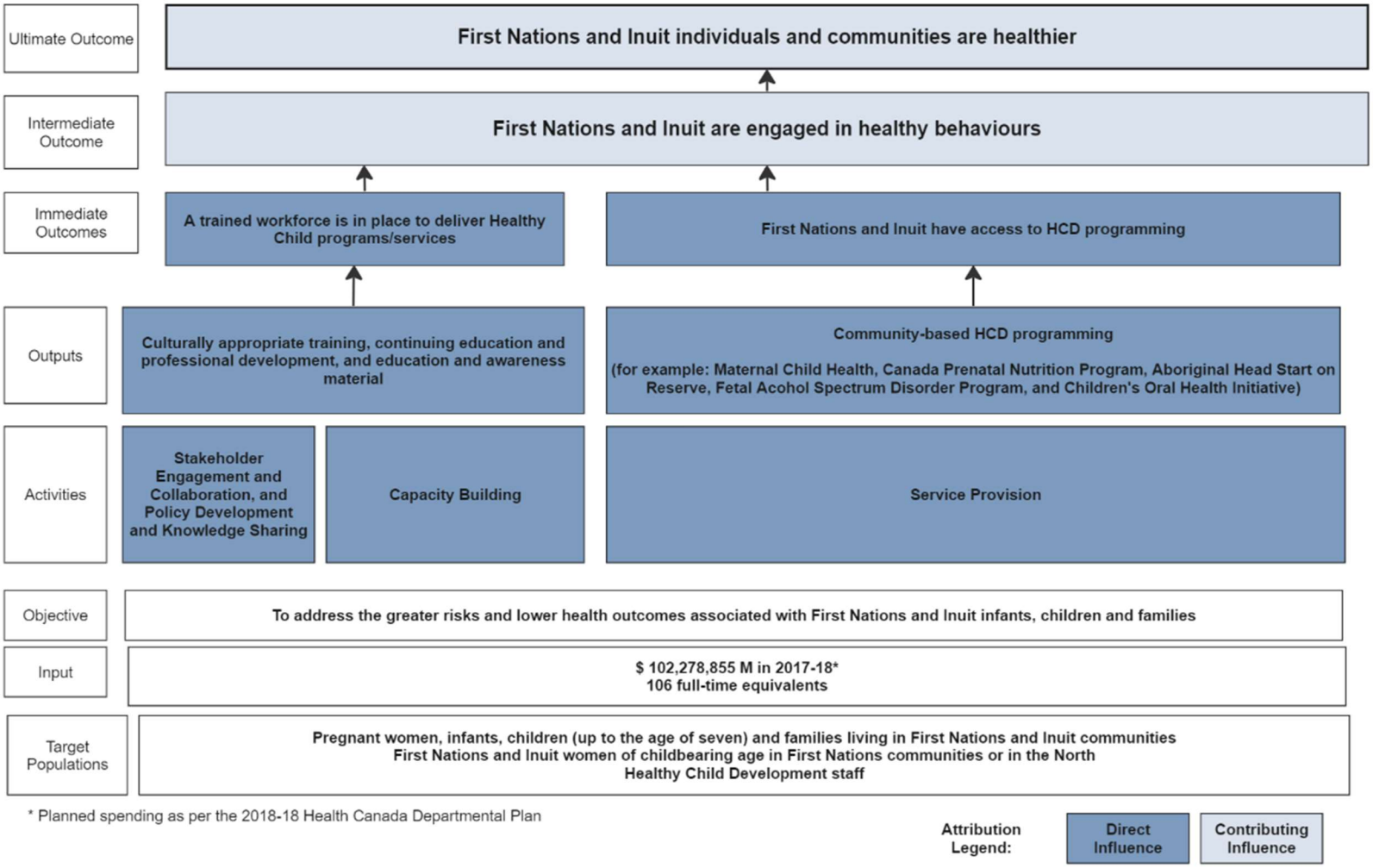
15. What are the challenges in delivering the HCD cluster?

V. Transfer of Services/Devolution and Thematic Issues

16. How might the delivery of HCD be improved to advance service transfer to Indigenous partners?
17. If service transfer was to happen, what would be necessary to make this feasible; how can the Department support this shift?
18. What impact has COVID-19 had on HCD programming?
19. What steps have been taken to mitigate the effects of COVID-19 on HCD programming?
20. How is climate change impacting HCD outcomes and the HCD program?

Appendix B: Logic Model

Figure 7: Logic Model for the HCD Cluster



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