

Improving the reach of early childhood education for First Nations, Inuit and Métis children

Jessica Ball, December 2014

This paper highlights deficits in key determinants of Aboriginal children's wellness and education outcomes. It focuses on the potential for early childhood programming, delivered in concert with other programmatic supports, to form a significant part of a comprehensive strategy involving all levels of government, in partnerships with Aboriginal groups, to ensure equity and dignity for Aboriginal young children and to improve outcomes for Aboriginal Peoples over the long term. Outstanding needs for population data and for research on program outcomes are also highlighted as part of the solution because they can inform investments and program improvements to ensure accountability and critical gains in opportunities for success and quality of life for Aboriginal children.



The *Moving Child Care Forward* project, funded by the Social Sciences and Humanities Research Council of Canada's Connections program, is designed to broaden and deepen debate and understanding of early childhood education and child care (ECEC) policy issues. The project's goals: knowledge mobilization to promote research, inform public and policy dialogue and to develop effective responses to complex policy issues to better serve young children and their families.

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Summary

This paper highlights deficits in key determinants of Aboriginal children's wellness and education outcomes. It focuses on the potential for early childhood programming, delivered in concert with other programmatic supports, to form a significant part of a comprehensive strategy involving all levels of government, in partnerships with Aboriginal groups, to ensure equity and dignity for Aboriginal young children and to improve outcomes for Aboriginal Peoples over the long term. Outstanding needs for population data and for research on program outcomes are also highlighted as part of the solution because they can inform investments and program improvements to ensure accountability and critical gains in opportunities for success and quality of life for Aboriginal children.

Overview

Aboriginal children in Canada¹ are more likely to live in poverty and face unacceptable challenges to their wellness and chances for success compared to their non-Aboriginal peers. They are less likely than non-Aboriginal children to have participated in an early childhood education program, more likely to repeat a grade in primary school, more likely to leave school without completing, more likely to live in foster care, more likely to have a child of their own during adolescent, more likely not to earn a post-secondary certificate, diploma or degree, and more likely to grow up to be unemployed and raising their own children in poverty. Their grim prospects are compounded by other persisting factors, including the multigenerational impacts that experiences in Indian Residential Schools has had on parenting abilities, wellness, and perceptions of mainstream schooling. Aboriginal children aged 14 and under more frequently live in a single parent household than their non-Aboriginal peers. Almost half of children aged 14 and under in foster care in Canada are Aboriginal.

Although some conditions for ensuring equity and dignity for Aboriginal children have improved, the quality of life for Aboriginal children, significant equity gaps remain in virtually every domain. Drawing upon findings of national and regional population surveys, government reviews, and research studies, this policy brief spotlights Canada's lacklustre performance with regards to honouring its commitments to Aboriginal children. These commitments are pursuant to the 1996 Royal Commission on Aboriginal Peoples, enshrined in various international declarations and conventions to which Canada is a signatory (Blackstock, Clarke, et al., 2004), and intoned in the Prime Minister's 2008 apology for the Residential Schools debacle (Office of the Prime Minister of Canada, 2008). Ensuring the conditions for quality of life, freedom from discrimination, opportunities to live in one's family of origin and to learn one's cultural heritage and language are among these commitments. Generally, fiduciary responsibility for the health, education, and welfare of First Nations children living on reserves is the responsibility of the Government of Canada,² while for other Aboriginal children, including Inuit, Métis, and non-status Indian

¹ Currently in Canada, Aboriginal people represent themselves politically as belonging to one of several major groups: First Nations (Status Indians on-reserve, Status Indians off-reserve, and non-Status Indians), Inuit, and Metis. These groupings reflect Section 35 of Canada's Constitution Act as well as the federal Indian Act, which defines the term 'Status Indian'. From a cultural perspective, Aboriginal people in Canada comprise over 50 distinct and diverse groups, each with its own distinct language and traditional land base.

² Section 35 (1) of the Constitution Act of 1982 recognizes Aboriginal and Treaty rights and affirms First Nations inherent right to self-government including the creation of laws and systems for the provision of lifelong learning for First Nations populations. First Nations expect

children living off reserves, meeting these needs may be a federal or provincial responsibility depending upon the specific sub-population and geographic location. Despite this responsibility and explicit recognition of enormous disparities, the federal government has not delivered on promises to rectify the persisting hardships incurred by ruinous colonial policy interventions into successive generations of Aboriginal Peoples. Although Canada has an *Aboriginal Action Plan* (Minister of Indian Affairs and Northern Development, 1997), there is no mechanism for monitoring the extent to which the plan is implemented. There is still no legal framework and no independent national children's commissioner to monitor implementation of children's rights federally and to co-ordinate federal, provincial, and territorial policies that affect children. These needed strategies were recommended in a 2007 Senate report (Canada, Standing Senate Committee on Human Rights, 2007).

It may be taken as axiomatic that the foundation for wellness, life-long learning, and contribution to society is laid down in the first few years of life (Jolly, 2007; McCain, Mustard, & Shanker, 2007). The extent to which a solid foundation is built in early childhood depends upon many intersecting determinants that create the conditions for quality of life for young children and their families (Irwin, Siddiqi, & Hertzman, 2007). This brief is centrally concerned with the maximizing the potential of early childhood programming to optimize and multiply the impacts of key determinants of child wellness in First Nations, Inuit and Métis communities, and Canadian cities. Research has established the many positive ways that participation in a high quality early childhood program can influence a person's developmental trajectory not only in later schooling but in subsequent family formation, mental health, and participation in the economy (Heckman, 2006; Keating & Hertzman, 1999).

This paper focuses on Aboriginal children's access to early childhood programs, such as Aboriginal Head Start program and other federal, provincial and territorial initiatives that are child centred and support families and communities to provide young children with nutrition, early stimulation, nurturance, and cultural learning. The brief emphasizes the need to increase investments at every level of government in quality early learning programs, including support for ensuring access by often marginalized segments within the Aboriginal population, including those in northern and remote communities, and those requiring transportation and Indigenous language provisions.

Turning the tide for Aboriginal children requires long-term, streamlined funding commitments that will enable communities to develop their own capacity and culturally appropriate, safe models for reaching young children and families, and to enable the development of coordinated, multi-sectoral efforts aimed at influence a broad set of ecological determinants over a sustained period of time (Ball & Moselle, 2013). The paper highlights the federally funded Aboriginal Head Start programs as positive contributions with even greater potential to function as sites for integrating and coordinating health promotion, disease prevention, early identification, referral, after-care and community development to improve children's overall quality of life.

Federal investment in professional education to substantially increase the skilled Aboriginal labour force for operating programs for young Aboriginal children and families, including early childhood education, is long overdue and could work to overcome challenges of staff recruitment, retention, and ongoing improvement. This paper also underscores the need to invest in scheduled, contextualized, disaggregated data collection about First Nations, Métis, Inuit and urban Aboriginal children's wellness. There is also a need for rigorous, longitudinal research to assess the effectiveness of early childhood

the Crown, not only to recognize their jurisdiction to lifelong learning, but also to "fulfill their Constitutional, Treaty and international obligations to First Nations peoples by supporting the design and implementation of First Nations comprehensive learning systems with adequate and sustainable resourcing" (First Nations Control of First Nations Education, p. 20).

programs as a strategy for improving quality of life and wellness of Aboriginal children. Knowledge development and mobilization is essential to the ongoing development of programs that target complex, over-determined and entrenched wellness and learning challenges through multifaceted interventions.

A distinctive population

Aboriginal children comprise a distinctive and growing segment of the Canadian population now and the parents, labour force, and social contributors to Canada in the future. Yet, while about one-fifth of Canadian young children experience a quality of life that most Canadians find unacceptable, Aboriginal children in Canada are arguably the most socially disadvantaged population. Measures of nearly every health and education indicator show Aboriginal children significantly struggling compared to their non-Aboriginal peers. As a population, Aboriginal Peoples in Canada have the lowest quality of life and the shortest life expectancies (Salee, 2006).

Aboriginal children are a rapidly growing proportion of all children in Canada, particularly in some western provinces (Manitoba and Saskatchewan) and in the Yukon, the Northwest Territories, and Inuit Nunangat. Among children aged 14 and younger in Canada, 7% are Aboriginal. They make up 28% of the total Aboriginal population. As a point of comparison, non-Aboriginal children aged 14 and younger make up 16.5% of the non-Aboriginal population (Statistics Canada, 2013). Aboriginal Peoples were among the fastest growing population segments in Canada from 2006-2011, growing at nearly four times the pace of the non-Aboriginal population (increase of 20.1% compared to 5.2%) (Statistics Canada, 2006, 2013).³ In 2011, over 1.4 million people identified as Aboriginal, making up 4.3% of the total Canadian population (Statistics Canada, 2013). The Aboriginal population is comprised of 60.8% First Nations, which is the fastest growing Aboriginal population (including 74.9% Registered Indians), 32.3% Métis, and 4.2% Inuit. Due to higher fertility rates and shorter life expectancies in all Aboriginal populations, the Aboriginal population as a whole is much younger (median age 28 years) than the non-Aboriginal population (median age 41 years). Population projections (Statistics Canada, 2011) estimate that by 2031, the Aboriginal population will remain younger than the non-Aboriginal population; the average annual growth rate of the Aboriginal population will range between 1.1% and 2.2% compared to an average annual growth rate of 1% in the non-Aboriginal population. By 2031, about one quarter of the population of Saskatchewan and one fifth of the population of Manitoba will be Aboriginal, up from about 18% currently. Rural residence is more common in the Aboriginal population (66%) than in the non-Aboriginal population (31%) and is expected to remain so.

The youthful nature of Aboriginal Peoples makes this demographic a potentially lucrative one for Canadian businesses, especially as baby boomers increasingly leave the labour force. The Aboriginal population of working age (25-64 yrs.) increased by 21% between 2006 and 2011, whereas other Canadians of working age increased by only 5% during this period (Statistics Canada, 2013). However, the unemployment rate for the working-age Aboriginal population has consistently been more than twice the rate for other Canadians (13% versus 6% in 2011) (Statistics Canada, 2013). Parental unemployment is related to the high number of Aboriginal children living in poverty and with sub-standard quality of life. Aboriginal children have a poverty rate of 40% - more than twice the national average (Macdonald & Wilson, 2013). For status First Nations children, many of whom live on reserves, the poverty rate is 50%, while the non-status, Métis and Inuit rate is 27% (Macdonald & Wilson, 2013).

³ Aboriginal people accounted for 3.8% of the population enumerated in the 2006 Census, 3.3% in the 2001 Census and 2.8% in the 1996 Census.

Aboriginal children trail behind other children in Canada on virtually every indicator of well-being and quality of life: infant mortality, health, education attainment, family income, crowding and sub-standard housing, homelessness, poor water quality, and lack of access to needed services. Lack of access to the conditions that enable Aboriginal young children to achieve their full potential will result in economic and social challenges for many Aboriginal children, families and communities for generations to come unless steps are taken now. While early childhood programs are not a panacea, they are important parts of a comprehensive strategy as focal points for children to develop foundational skills in safe, nurturing environments, and for families and communities to gain access to needed services and supports. Discussed later in this brief, the federal government's investment in Aboriginal Head Start and a handful of other early childhood initiatives are bright light in an otherwise gloomy landscape of federal government initiatives to support the well-being of Aboriginal children. Significantly increased federal investments are needed in order for these bright lights to shed rays of hope on a larger portion of Aboriginal children.

Indicators of Aboriginal children's developmental wellness

As yet there is no one survey that has gathered data about wellness, education or quality of life of all segments of the Aboriginal population; national collection of comparable data across Métis, Inuit, First Nations on reserves and urban Aboriginal populations is an outstanding need (Loppie & Wien, 2009; Smylie & Anderson, 2006). Moreover, there is no survey or compilation of surveys that yields a comprehensive picture of wellness or education of all populations of Aboriginal young children.⁴ The only population survey of Aboriginal young children (6 months to 6 years old) was the 2006 Aboriginal Children's Survey (ACS), funded by Human Resources Development Canada and conducted by Statistics Canada as a post-censal survey guided by a largely Aboriginal technical advisory committee. This survey did not obtain permission to collect data on reserves, but the survey does allow disaggregation of data about Métis, Inuit and First Nations children living off reserves. The ACS yielded the first quantitative, parent-report data enabling disaggregated and combined analyses of development trends, estimates of health problems and developmental difficulties, and information on the perceived accessibility and frequency of utilization of programs and services for Inuit, Métis, and First Nations children living off reserves across Canada. A perspective on selected aspects of the wellness of First Nations children living on reserves has been provided by the First Nations Regional Longitudinal Health Survey (RHS). Funded by the First Nations/Inuit Health Branch of Health Canada, the RHS is the only First Nations governed national health survey in Canada. In three waves of data collection (1997, 2002/3, and 2009/10), a team based at the Assembly of First Nations coordinated with 10 independent RHS Regional Partners across Canada to plan, conduct and analyze the survey, relying on parents' reports. The survey gathered data only on children aged 0-11 years, precluding conclusive findings specifically about young children. Despite enormous knowledge gaps, it appears that funding for either the RHS or ACS has not been renewed, leaving a critical gap in information about Aboriginal young children.

There is an outstanding need for federal investment in a process that respectfully, comprehensively, rigorously, and consistently collects contextualized data from First Nations, Métis and Inuit Peoples, including First Nations on reserves where the information gap is greatest. Policies related to collection of such data are discussed in a seminal report on Indigenous children's health (Smylie & Adomako, 2009). The survey tool developed for the ACS by the Aboriginal Technical Advisory Committee offers a unique, core set of culturally appropriate, comparable indicators of First Nations, Métis, and Inuit young

⁴ Aboriginal children were not systematically sampled in the two national longitudinal cohort studies of the growth and development of Canadian children and youth (*National Longitudinal Study of Children and Youth* and *Understanding the Early Years*).

children's wellness on dimensions that reflect key stakeholders' desired vision of healthy young children. Meanwhile, gathering a picture of Aboriginal children's development and circumstances requires a synthetic process relying upon data-bases with varying inclusion criteria, as well as proxies, anecdotal and non-formal reports, and a scattering of program evaluations that have not involved rigorous methodologies and are far from conclusive.

Social determinants of Aboriginal children's wellness

Family life

The quality of life of children everywhere pivots on the well-being of their primary caregivers. No doubt, some Aboriginal children and their primary caregivers are thriving; there are growing numbers of Aboriginal young people who are healthy, proud of their cultural identity, and contributing in every sector of Canadian society. Unique strengths of Aboriginal family life have been described by Aboriginal scholars (Anderson & Lawrence, 2003). Values and approaches that inform socialization in many Aboriginal families include: a recognition of children's varying abilities as gifts; a holistic view of child development; promotion of skills for living on the land; respect for a child's spiritual life and contributions to the cultural life of the community; transmission of a child's ancestral language; and building upon strengths more than compensating for weaknesses (Anderson & Ball, 2011). Aboriginal children (9.1%) are more likely than non-Aboriginal children (3.9%) to live with at least one grandparent (Statistics Canada, 2012). A child welfare study (Trocme, Fallon, et al., 2005) found that First Nations children were not over-represented among reports for child abuse compared to other children, suggesting some protective factors at work in families, however impoverished.

The ACS found that play is an important part of Aboriginal children's daily activities, including arts and crafts, role playing games, and playing outside (Guèvremont, 2010). For example, with reference to First Nations children living off reserves, parents reported that 94% play outside daily in warm weather, and about 40% play outside daily in cold weather. About half of off-reserve First Nations children go hunting, fishing, or camping and about one third participate in seasonal, outdoor activities such as berry picking or gathering wild plants. About half of parents of First Nations children reported that someone, usually a parent or grandparent, helps the children understand First Nations culture and history. About 14% of First Nations children attend child and parent programs (e.g., Moms & Tots; The Dad Program; or Mother Goose). Eight out of 10 parents reports that their 4-5 year old child living off reserve was in some type of early education program, and about half reported that their 2-5 year old child attended child care, typically a daycare centre.

Yet, along with these positive trends, many Aboriginal parents of young children today are struggling. Aboriginal leaders and scholars have asserted that, as a group, difficulties with parenting, mental health and addictive behaviors, and domestic violence are direct consequences of the ways their parents were negatively affected by colonization, including residential schooling either as children forced to attend or as children of residential school survivors (Dion Stout & Kipling, 2003; Fournier & Crey, 1997; Mussell, 2005; Royal Commission on Aboriginal Peoples, 1996; Smolewski & Wesley-Esquimaux, 2003). The last residential school, Gordon Residential School in Saskatchewan, closed in 1996. In 2002, it was estimated that one in six First Nations children under 12 years of age had one or both parents who had attended a residential school (Trocme, Knoke et al., 2005). Such colonial legacies are relevant to a range of policy areas, including residential school healing programs, education and support for mothers and fathers during the transition to parenthood, infant development programs, quality child care, family strengthening initiatives, family literacy, community development, employment, and social justice.

Findings of the 2011 census portray a challenging family structure for many Aboriginal children. Aboriginal children (34.4%) are more likely than non-Aboriginal children (17.4%) to live in single-parent households, which is associated with an increased likelihood of growing up in poverty. Among urban-dwelling Aboriginal children specifically, over 50% live in single-parent homes, compared to 17% of non-Aboriginal children living in single-parent homes. The vast majority of Aboriginal single-parent homes are headed by mothers. More Aboriginal than non-Aboriginal mothers are single and more are adolescents. In fact, the number of First Nations children born to teenage girls has remained high since 1986 at about 100 births per 1,000 women, a rate that is seven times higher than for other Canadian teenagers, and comparable to the teen fertility level in least developed countries such as Nepal, Ethiopia and Somalia (Guimond & Robitaille, 2008). Whereas countries such as the United States implement programs to meet some of the unique needs of teen parents, there are few examples of such programs in Canada. About one-third of Aboriginal children live in a lone parent family compared with 17.4% of non-Aboriginal children. Nearly 4% of Aboriginal children are in foster care compared to 0.3% of non-Aboriginal children (Statistics Canada, 2013).

Aboriginal fathers' elusiveness in their children's lives has been widely interpreted as indicating their indifferent attitudes (Claes & Clifton, 1998; Mussell, 2005). Yet, a study by Ball (2009) suggested that their marginal living conditions (and prevalent mental and physical health problems, combined with overwhelming negative social stigma, likely interact to create formidable obstacles to their involvement in caring for their young children. Research about non-Aboriginal fathers shows significant correlations between father involvement and developmental outcomes for children, mothers, and fathers (Allen, Daly & Ball, 2012). Father absence is associated with more negative developmental and health outcomes for children and for fathers. At the same time, lone-father headed households are twice as common for First Nations children living on reserves than for Canadian children as a whole (Health Canada, 2003), and for Inuit children (Statistics Canada, 2006). In 2011, 6% of Aboriginal children were being raised by lone fathers. There is no federally supported program specifically designed to help Aboriginal fathers become effective supports for their children's health and development (Ball & George, 2007).

Aboriginal child welfare

There is a staggeringly high number of Aboriginal children in the care of the government – approximately three times the number enrolled in residential schools at the height of their operations or at any time in Canada's history (First Nations Child and Family Caring Society, 2005). In some provinces, Aboriginal children out-number non-Aboriginal children in care by a ratio of 8 to 1. The rates compare with 0.67% of non-Aboriginal children. This pattern of being placed in the care of the state continues the time-worn pattern of government apprehension of Aboriginal children for confinement in residential schools, foster homes, and permanent adoptions. Government interventions over generations have resulted in large numbers of Aboriginal children losing their connections to family, community, and culture.

The *Canadian Incidence Study of Reported Child Abuse and Neglect* (Trocme, Fallon, et al. 2005) found that the primary reason Aboriginal children enter the child protection system is neglect, including physical neglect, lack of supervision of a child at risk of physical harm, or other examples of inadequate provisions for a child's health, safety or education. The study found that among children coming to the attention of the child protection system, Aboriginal children are twice as likely as non-Aboriginal children to be part of a family who survives on social benefits and lacks full time employment, at least twice as likely to live in public housing or housing that is unsafe or overcrowded, and many times more likely to have family members engaged in chronic patterns of substance misuse (Trocme et al., 2005; Trocme et al., 2006).

Ensuring the well-being of First Nations children living on reserves is a federal responsibility under Canada's constitution, and therefore the Department of Indian and Northern Affairs must fund child welfare services. The Assembly of First Nations (2006a) has commented that there is insufficient funding to support some First Nations families – especially those living on reserves - to keep their children safely at home, coupled with seemingly unlimited funds to remove them. The Canadian Human Rights Tribunal is currently hearing a case concerning a 22% deficiency in funding for First Nations child welfare services compared to other Canadian children (Assembly of First Nations, 2013).⁵ Shortfalls in funding for prevention and early intervention programs in communities on reserves have been acknowledged by the Department of Indian and Northern Affairs (Blackstock et al., 2005). In addition, there is no program within the Department that actively supports and monitors the range of prevention and early intervention service (Blackstock et al., 2005) - services that are available to other Canadian children through the provincial system.

Drawing on evidence from the Canadian Incidence Study of Reported Child Abuse and Neglect (Trocme et al., 2005), the First Nations Child and Family Caring Society (2005) has recommended a number of less disruptive measures than removing children from communities, including: support for improved parenting; more supervision of children through placement in quality child care and development programs during the day; local access to services that the child or parent needs; supplementary food resources; or foster care with a relative instead of removing a child from the community to a foster placement where the child cannot remain in contact with family members. Few of these recommendations have been acted upon. In situations involving young children, all of these recommendations could be implemented through elaboration and expansion of child centred, family involving early childhood programs.

Education

Education outcomes for Aboriginal children are improving, with more Aboriginal people attaining a high school diploma. It is possible that this development is attributable in part to the impacts of participation in Aboriginal Head Start programs in urban communities, though follow-up studies have not been conducted. In any case, this trend bodes well for the future: several surveys, including the 2012 Aboriginal Peoples survey, have found higher percentages of high school completers had a mother and/or father with at least high school education (e.g., Statistics Canada, 2013). The 2011 National Household Survey found that 60.2% of First Nations people aged 25 to 64 had completed at least a high school diploma; 73.6% of Métis aged 25 to 64 with at least a high school diploma, and 41.0% of Inuit aged 25 to 64 had completed at least a high school diploma. In comparison, 89% of the non-Aboriginal population had at least a high school diploma. The Aboriginal-non-Aboriginal gap may be narrowing specifically for First Nations living off reserve: the 2012 Aboriginal Peoples Survey found that 72% of First Nations people living off reserve had completed a high school diploma (Statistics Canada, 2013). Adults aged 18 to 44 who had finished high school were more likely to be employed than those who did not have a diploma. Among First Nations people living off reserve, the percentages employed were 72% for completers versus 47% for leavers, while they were 71% versus 44% among Inuit, and 80% versus 61% among Métis. In terms of earnings, among First Nations people living off reserve and Métis, the median employment income ranges for completers were \$10,000 higher than for leavers. Among Inuit, the difference in median employment income between completers and leavers was \$20,000. Given that

⁵ Recently it was divulged that the Government of Canada has withheld tens of thousands of documents that it was obligated to disclose to lawyers representing the AFN and the First Nations Child and Family Caring Society under the human rights commission rules. The Government has requested that the proceedings be put on hold while they gather the more than 50,000 documents.

attainment of a high school diploma or higher has been shown to improve labour market outcomes for Aboriginal people (Sharpe & Arsenault, 2009), clear incentives exist for the Canadian government to make Aboriginal education a priority.

While education and related outcomes may be improving for First Nations living off reserves, the findings of several surveys have found that high school completion has not improved for First Nations living on reserve or for Métis or Inuit since information gathered in the 2006 Aboriginal Peoples Survey. Lack of engagement and success in education tends to be multigenerational. Many Aboriginal children's parents or grandparents were excluded from mainstream schooling and may have been more harmed than helped by formal education (Grant, 1996). Some Aboriginal parents understandably may be unsure whether to trust the public education system, and unsure of how to support their children's engagement in formal schooling, including what kinds of early stimulation may help to prepare them for school. Aboriginal leaders and agencies across Canada have long argued that overall lack of services before children enter formal schooling and during the primary school years, as well as culturally inappropriate tools for monitoring, screening, assessing, and providing extra supports, frequently result in serious negative consequences for Aboriginal children (First Nations Child and Family Caring Society, 2005; Royal Commission on Aboriginal Peoples, 1996), including: over- and under-recognition of children with developmental challenges, early intervention services introduced too late, undermining Indigenous language and cultural goals for development through an over-valuing of standard urban English and of monolingualism, cultural alienation, low levels of school readiness, and high rates of early school failure and premature school leaving. The Canada Council on Learning (2007) speculated that high rates of early school leaving among Aboriginal youth may reflect their struggles to develop their full potential for language and literacy. The 2006 Aboriginal Peoples Survey found that pregnancy and needing to care for a child were the primary reasons given by 25% of First Nations women living off reserve and Métis women, and by 38% of Inuit women.

There is also a significant gap in post-secondary education that would prepare Aboriginal people for participation in the skilled labour market. In 2011, according to the voluntary National Household Survey (a potentially biased sample), 22.8% of Aboriginal people aged 25 to 64 reported having a high school diploma or equivalent as their *highest* qualification, while 23.2% of non-Aboriginal people aged 25 to 64 had a high school diploma or equivalent as their *highest* qualification. Aboriginal people (28.9%) are more than twice as likely *not* to go on from high school to obtain a post-secondary certificate, diploma or degree compared to non-Aboriginal people (12.1%) (Statistics Canada, 2013). The 2012 Aboriginal Peoples Survey also showed that 43% of off-reserve First Nations people, 26% of Inuit, and 47% of Métis aged 18 to 44 had postsecondary credentials, that is, a certificate, diploma or degree above the high school level. These figures are comparable to those from the 2006 Aboriginal Peoples Survey. The corresponding figure for the non-Aboriginal population in 2011 was 64%, according to the National Household Survey.

Health

Aboriginal children are more likely to suffer poor health than are non-Aboriginal children, and that their poor health status is likely to affect their development and life chances (Hackett, 2005; Kirmayer, Simpson et al., 2003; Loppie & Wien, 2009). For example, they are more likely to be born prematurely, to die before their first birthday⁶, to have baby bottle tooth decay, to be diagnosed with Fetal Alcohol Syndrome Disorder, to suffer accidental injury, to have a chronic respiratory condition, to have a

⁶ Infant mortality – a fundamental indicator of the wellness and human development of a population – is higher in the Aboriginal population, with eight deaths per 1000 live births among First Nations on reserves, and 16 deaths per 1000 live births in Nunavut, compared to 5 per 1000 live births in the general population (Government of Canada, 2008).

disability, and to start school with hearing loss and speech language difficulties (Ball & Moselle, 2013). Life expectancy at birth for Aboriginal peoples, though increasing, is an average of five to 10 years less for First Nations and Inuit peoples than for Canadians as a whole (Canadian Institute of Health Information, 2004).

For Aboriginal children in the north, service inequities coupled with food and water contamination and changes in climate and hunting regulations are resulting in malnutrition along with the dissolution of traditional forms of subsistence and family life (Kovesi et al., 2007; Kuhnlein, Soueida, et al., 1995; UNICEF Canada, 2009). The Inuit population has one of the highest suicide rates in the world; for girls it is 20 times greater than the rest of Canada, and for boys it is 35 times higher (Oliver, Peters, et al., 2012). According to data from the Canada Mortgage and Housing Corporation (2004), at least 33% of Inuit people and First Nations people living on reserve, and 24% of First Nations children living off reserves live in inadequate, unsuitable, or unaffordable housing, compared to 18% of non-Aboriginal people.⁷ Inappropriate housing construction materials, over-crowding, and inadequate ventilation cause spread of contagious diseases. A study by Kovesi and colleagues found that Inuit infants in the Baffin region of Nunavut have the highest reported rate of hospital admissions in the world, because of severe respiratory syncytial virus (RSV) lung infections, with annualized rates of up to 306 per 1000 infants (Kovesi, Gilbert et al., 2007). This study found that among Inuit infants admitted to hospital, 12% require intensive care, which often means being airlifted to hospitals in southern Canada. Inuit infants have disproportionately high rates of permanent chronic lung disease following a lower respiratory tract infection.⁸ A study of indoor air quality found that Inuit young children lived in homes with an average of 6.1 occupants, compared to young children in southern Canada living in homes with an average of 3.3 to 4.4 occupants). In some Inuit communities, over half the population has dietary exposure levels of mercury, toxaphene, and chlordane exceeding the provisional tolerable daily intake levels set by Health Canada and the World Health Organization (Chan et al., 1997).

Related to housing problems, First Nations children living on reserve encounter a number of chronic health conditions often triggered by environmental contaminants, including tobacco smoke and mould (First Nations Regional Longitudinal Health Survey (RHS) 2002-03: Results for Adults, Youth and Children Living on First Nations Reserves. Ottawa: First Nations Centre, National Aboriginal Health Organization, 2005). The most common conditions are asthma (14.6%), allergies (12.2%), chronic middle ear infections (9/2%), and bronchitis (3.6%). The ACS reported the same problems (Findlay & Janz, 2012), and the RHS found the same problems persisting with similar frequencies into adolescence (First Nations Governance Centre, 2012). The prevalence of middle ear infection (otitis media) among Aboriginal children in the north is 40 times that found in the urban south, with as many as two-thirds of Aboriginal children starting school with a mild to moderate conductive hearing loss (Bowd, 2005). Hearing loss is associated with speech and language delays and disorders, which are the most frequent parent-reported problem for Aboriginal children, and the most frequent reason for parent dissatisfaction with wait times for

⁷ Aboriginal homes are often made of low quality construction and have poor ventilation, inadequate plumbing for the number of residents, and unreliable supplies of clean water. The RHS (First Nations Information Governance Centre (2012) found that First Nations households on reserve with children have an average of 3.4 children compared to 1.1 children in general Canadian households. Both in 2002 and 2010, on average, First Nations children live with 5.7 household members at least half the time. One in three First Nations people consider their main drinking water unsafe to drink, and 12% of First Nations communities have to boil their drinking water. Six percent (over 5,000 homes) are without sewage services, and 4% lack hot water, cold water or flushing toilets (Assembly of First Nations, 2006b).

⁸ A study of indoor air quality found that Inuit young children lived in homes with an average of 6.1 occupants, compared to young children in southern Canada living in homes with an average of 3.3 to 4.4 occupants). Most of the homes studied were smaller than 93 square metres (1,000 sq. ft.). In 80% of the houses, ventilation rates were below the recommended Canadian standard, while carbon dioxide levels far exceeded recommended concentrations – an indicator of crowding and reduced ventilation. Smokers were present in 93% of the homes.

clinical ancillary services (Findlay & Janz, 2012). Out-of-home placement in a series of over-crowded, non-Aboriginal foster homes in order to access health care is also much more common among Aboriginal than non-Aboriginal children, particularly in the North.

Access to Health services

Long-standing inequities persist between Aboriginal and non-Aboriginal children in access to health services, particularly for First Nations children living on reserve and for children in northern, remote and isolated communities (Adelson, 2005; deLeeuw, Fiske, et al, 2002; Health Canada, 2005; Loppie & Wien, 2009). In 2004, the Assembly of First Nations (2004) put forward a First Nations Health Action Plan, calling for First Nations controlled and sustainable health promotion and health care systems that embody holistic and culturally appropriate approaches. There were some steps taken, including the creation of Aboriginal-driven initiatives such as the National Aboriginal Health Organization, the Aboriginal Healing Foundation, the Aboriginal Health Transition Fund, the First Nations Regional Longitudinal Health Survey, and creation of an Aboriginal Technical Advisory committee to guide the new post-censal Aboriginal Children's Survey. However, all of these initiatives have been discontinued. There has been some transfer of authority and control over health and social services to Aboriginal Peoples in some places. New federal health program funding is often afforded only to selected communities and, judging by available health data, is far from adequate.

Poverty

Many wellness and education deficits of Aboriginal children reflect the cumulative effects of pervasive poverty and social exclusion (Canadian Institute of Child Health, 2000). Deficiencies in developmental environments before birth and during early childhood tend to have lasting negative impacts on subsequent health, readiness to learn, lifelong physical and mental health, and quality of life (Irwin, Siddiqi, & Hertzman, 2007; Keating & Hertzman, 1999). Persistent, substantial structural disparities between Aboriginal and non-Aboriginal peoples have been documented for over half a century in Canada (e.g., (Assembly of First Nations, 2006b; Hawthorn, 1966; Royal Commission on Aboriginal Peoples, 1996) and are well-known to policy-makers. The National Council of Welfare (2007) linked the high impoverishment of Aboriginal families to their "tremendous programming needs, reliance on food banks, and cyclical poverty" (p. 26). In a 2008 study, using indices of 'quality of life' in communities based on labour force activity, income, housing and education, the 'bottom 100' of nearly 4700 Canadian communities included 92 First Nations communities, while the 'top 100' included only one (Pesco & Crago, 2008).

Aboriginal children experience the highest rate of poverty compared to other segments of the population of Canadian children; estimates range from 41% to 52.1% of Aboriginal children living below the poverty line.⁹ The average household income of Aboriginal children's families is almost three times lower than that of non-Aboriginal Canadians (Statistics Canada, 2013). According to the 2008 report card on child and family poverty in Canada by Campaign 2000, one in four children in First Nations communities live in poverty, compared to one in nine Canadian children living in poverty overall.

Many Canadian service providers, educators, and commentators tend to see Aboriginal children as 'at risk' for negative development outcomes as they grow up (e.g., for depression, substance abuse, suicide, involvement in the sex trade, homelessness), as if the challenges affecting Aboriginal children resided within them. This view supports the idea that Aboriginal children must be protected from being at risk through more focused efforts to make them ready for public school (e.g., by promoting early reading, early numeracy, and proficiency in the dominant language of instruction), by providing extra learning

⁹ Estimates depend on criteria for defining poverty and whether estimates include children with Aboriginal identity or ancestry.

supports in special classrooms, and in some cases by placing them in the care of the government. This view fails to take full account of structural risks, such as poverty, environmental degradation, exposure to racism, and lack of community-based programs that promote health and family development, operated by Aboriginal people. Thus, for example, high morbidity in early childhood, apprehension of Aboriginal children into state care, and early school leaving cannot be reduced only by investing in more medical care, more parent education programs, and more targeted school-based interventions. The gravity of the situation for Aboriginal young children calls for fundamental changes in policies and programs, as well as in the goals, attitudes and understandings that drive them.

Government funds have been found in 'emergencies' when health problems are declared to have reached 'epidemic' proportions in specific communities (e.g., in 2005 during a health crisis in Kachechewan as a result of contaminated drinking water, or in 2007 during a suicide epidemic in Hazelton, B.C. attributable to a devastated local economy and multi-generational trauma from residential schools). There is an outstanding need for sustained investment to produce long-term improvements in the conditions in which Aboriginal young children are growing up.

Jurisdictional disputes in provision of services

For First Nations young children living on reserves, a barrier to accessing needed medical and clinical ancillary services is jurisdictional disputes between and amongst federal and provincial governments about which level of government will cover the costs. A study in a sample of 12 First Nations child and family service agencies in 2005 found nearly 400 cases of jurisdictional disputes affecting timely service access in a one year period (First Nations Child and Family Caring Society of Canada, 2005). Jordan's Principle, passed in the House of Commons on December 12, 2007, states that where a jurisdictional dispute arises between or within governments regarding services to a Status Indian child, and these services are otherwise available to other Canadian children, the government of first contact pays for the service without delay or disruption and resolves the jurisdictional dispute later (Lavallee, 2005). However, reports of jurisdictional disputes continue to surface and the need for streamlined, child-centred policies and practices to ensure timely access by First Nations children on reserves to needed services is urgent.

Conclusions about social determinants

Aboriginal leaders and agencies across Canada have been vocal for some time about the overall lack of services and culturally inappropriate models of services, which are seen as significant contributors to poor health and negative health trajectories for Aboriginal children (Canadian Centre for Justice 2001; First Nations Child and Family Caring Society, 2005; Native Council of Canada, 1995; Royal Commission on Aboriginal Peoples, 1996). Studies have pointed to alarming inequities in overall quality of life (Ball, 2008; Salee with Newhouse & Levesque, 2006) and timely access to a healthy food environment (Elliott, Jayatilaka, Brown, Varley & Corbett, 2012), clinical ancillary services (de Leeuw et al., 2002), supports for young parents, and supports for children with special needs (Centre of Excellence for Children with Special Needs). In the two decades since Aboriginal leaders began to call for greater alignment between health, education, social development and housing sectors in order to improve health outcomes, there has been growing awareness both nationally (Leitch, 2008) and internationally (Bennett, 2003) of persisting health gaps, fragmentation and duplication of services, lack of cultural appropriateness and safety of services, and overall unmet health needs of Aboriginal children and families.

There is an outstanding need for structural reforms, cross-sectoral alignment, and integrated efforts to address the multiple determinants of Aboriginal children's living conditions and opportunities for wellness and success. This section has highlighted findings about a few key indicators of equity gaps and

outstanding needs. The next section identifies strategies for coordinated action and exemplary programs that hold promise as part of the mix of investments required to close equity gaps for young Aboriginal children.

Early Childhood Care and Education

Aboriginal-specific conceptualizations of health and wellness emphasize a holistic concept of wellness that includes the spiritual, mental, physical and emotional wellness of all family members, and embed these within a broad ecological system (e.g., Loppie and Wien, 2009; UNICEF, 2009). This view positions the child, and support for children within the context of their family, in the centre (Anderson & Ball, 2011). Extensive research has shown that targeted investments in a range of community-fitting programs during the early years can promote healthy development in both children and families, counteract stressors and deprivations that can erode opportunities for optimal health and development, and make a significant contribution to educational achievement, economic success and subsequent parenting of the next generation (Cleveland & Krashinsky, 2003; Heckman, 2006; McCain, Mustard, & Shankar, 2007; Shonkoff & Phillips, 2000; World Health Organization, 2007). Strategic, integrated and intersectoral programming to improve timely, affordable access to supports for optimal early childhood development is achievable if there is political will to commit long-term investments and facilitate streamlining. Early childhood programs can become focal points in communities for the provision of a host of direct services, early identification and referrals in areas that are key contributors to outcomes, including early learning, parenting education and support, nutrition, prevention, early identification, primary health care, and clinical ancillary services for Aboriginal young children.

Child and Youth Programs in First Nations and Inuit Communities

By far the greatest disparities in wellness and academic success are found among First Nations children living on reserve and Inuit children. Health Canada delivers a cluster of Child and Youth (CY) programs through the First Nations and Inuit Health Branch (FNIHB). FNIHB is involved with 596 (96.9%) of the 615 First Nations south of the 60th parallel, and funds one or more CY programs in 546 (91.6%) of the 596 First Nations. Many of these programs for children and youth reach out especially to families needing extra support to provide adequate supervision, nutrition, and nurturance for their children. Some programs reach out to children with health or developmental challenges.

The Canadian Prenatal Nutrition Program (CPNP) is essentially a national (universal program), while the coverage of the other three CY programs, noted below, is based upon regional agreements between FNIHB and First Nations and their regional organizations. FNIHB Regions have established practices that determine how funding is distributed within the region. Some regions fund all communities while other regions fund projects in specific communities. Expenditures for the four CY programs in millions of dollars for 2008/2009 were:

- Aboriginal Head Start on Reserve: planned \$59.02, actual \$50.58
- Canada Prenatal Nutrition Program: planned \$14.15, actual \$11.20
- Fetal Alcohol Spectrum Disorder: planned \$17.65, actual \$20.04
- Maternal Child Health: planned \$29.95, actual \$23.60

Based on available information (Health Canada, 2010), there is insufficient CY funding to provide for full coverage of all CY programs to all First Nations communities on reserves. For example, only 202 (33.9%) First Nations are funded for all four CY programs (Health Canada, 2010). Beyond funding shortfalls, shortage of staff resources was identified as the main barrier to service by 68.8% of community staff respondents in the CY Cluster Study (Health Canada, 2010).

A cluster-based evaluation of Child and Youth (CY) programs of FNIHB conducted in 2008-2009 found that CY programs are relevant and effective in contributing to improving the health of First Nations children when they and their families participate in the programs. However, many cluster study respondents made a link between the current program-based funding approach and the lack of a unified, cluster approach. As well, more than half the respondents identified barriers or constraints to service delivery and access, including: lack of child care (71.2%), shortage of staff (68.8%), and transportation (59.1%). Lack of services to assist children living with special needs was identified as an unmet need by 68% of FNIHB staff. Availability of services in a First Nations language was identified as a barrier for some community members. Significantly, in the survey of community members, the study found that 26.6% said that they had been placed on a waiting list, most frequently for enrolling their child in AHSOR. Of those, 40.8% said they waited for less than one month, 38.8% said 1 to 3 months, and 20.4% said they were still waiting.

Out-of-home Early Learning Opportunities

Unlike most high-income countries, Canada lacks a national strategy to ensure access to quality programs to promote optimal early development and learning either for all children or for children in an identified risk category or equity group. Although the current 'catch-as-catch-can' collection of ECCE programs increases many children's vulnerability, the situation is vastly bleaker for Aboriginal children (Bennett, 2003); as of 2009, less than 18% of Aboriginal children had access to any ECCE program (Leitch, 2008). The number and distribution of spaces for Aboriginal children in out-of-home ECCE programs falls far short of demand.

Aboriginal Head Start (AHS)

Federal funding was committed in 1995 for Aboriginal Head Start (AHS) programs on reserves and in 1998 for programs off reserves in urban and northern communities. This initiative was a federal response to calls by Aboriginal community representatives, leaders, and practitioners for an adequately resourced, sustained, and culturally based national strategy to improve supports for Aboriginal young children's health, development, and early learning. AHS is the most extensive, innovative, and culturally based initiative early childhood development initiative for Aboriginal preschool children and families in Canada. AHS has led to growth of capacity in First Nations, Métis, and Inuit people to deliver culturally based ECCE in their communities.

There are two AHS programs. AHS in Urban and Northern Communities (AHSUNC) serves First Nations children and families living off reserve and Inuit and Métis children and families. Aboriginal community organizations design and deliver the program through funding provided by the Public Health Agency of Canada. AHS On Reserve (AHSOR) is operated by Health Canada and serves children and families living on reserves.

Based on a community empowerment model, both the AHSOR and AHSUNC programs use a centrally mandated set of program dimensions and a decentralized approach to specific program design and curriculum decision making so that each community can design a program that meets local needs, draws on local assets, and supports that community's vision for children's early learning. Local control of AHS programs enables a community to integrate or co-locate other programs and services, such as speech-language pathology, dental hygiene, or community nursing, as needs and resources allow.

Although a standard model does not exist at the national level, the following summary descriptions are generally applicable to both AHSOR and AHSUNC programs.

- AHS recognizes the multi-dimensional aspects of well-being for Aboriginal children and therefore share common objectives, focussing on child health and well-being that extends beyond a school readiness program by providing health promotion programming from a holistic perspective. As well, they share the same six components: education; promotion of Aboriginal culture and language; health promotion; nutrition; parent involvement; and social support.
- AHS programs can be delivered in a variety of settings. In addition to centre-based programming, there are a number of other models that are often used within the program. Some sites offer a home visiting component, whereby project staff will visit families in their homes, providing information and counselling to parents, and educational activities for children. Other program activities include workshops and skill development sessions for parents, joint parent and child workshops and special cultural events and activities for families.
- AHS programming may be provided alongside or integrated with various child care and development programming that is funded through other programs. For example, in on reserve First Nations communities, daycare programs are funded through Aboriginal Affairs and Northern Development Canada as well as Human Resources and Skills Development Canada, while off reserve these are funded by provincial/territorial and local programs.
- Most programs run free of charge to participants.

AHS has a number of positive and promising features that are highly congruent with principles of holism, cultural grounding, and community determination advocated by many Aboriginal organizations.

- AHS programs are providing safe, supervised, stimulating environments for young children. This is especially important for children whose primary caregivers are struggling with physical or mental challenges or whose home environments may be crowded, chaotic, or contaminated. Some programs provide nutrition supplementation, cognitive stimulation, socialization with Aboriginal peers, adult role models and Elders, and exposure to Indigenous language and spirituality. These opportunities are valued by Aboriginal parents and promote children's health and wellness.
- AHS programs help to fill gaps in services to support families during the early stages of family formation, when parents – many of them very young and with few resources – need social support and practical assistance.
- AHS has been a timely and effective vehicle to enable communities to deliver ECCD programs in culturally fitting ways to children who need them most. AHS programs have the flexibility to develop in ways that are family-centred, family-preserving and delivered within a community development framework. The programs are informed by the communities' internally identified needs and vision for improving the quality of life of young children and their families.
- The programs are increasing the numbers of Aboriginal people who are skilled in delivering programs for Aboriginal children and families.
- AHS programs provide a place within communities that may otherwise lack the hard and soft infrastructure for health promotion and chronic disease prevention and for early identification, referral, and coordination across health, social and child welfare programs to ensure accessible services for children. Thus, an AHS program often becomes a site for multi-service integration and inter-sectoral coordination: additional programs are integrated directly into the AHS program or co-located to streamline access by children and their primary caregivers to specialists including speech-language pathologists, physiotherapists, occupational therapists, dental hygienists, and to other services, such as diabetes prevention, chronic disease case management, mental health crisis intervention, and substance abuse treatment (Ball, 2005; FNIHB, 2012). Anecdotal reports in the 'gray literature' such as AHS program reports (Health

Canada, 2002) and program newsletters, often describe how the programs help the families of participating children to access food, warm clothing, income assistance, health, mental health, and social services.

Evaluation of AHS

Based on limited available evidence gathered in the only national program evaluation that has been conducted (Public Health Agency of Canada, 2012), the AHSUNC program has had a positive effect on school readiness, specifically in improving children's language, social, motor and academic skills, cultural literacy, and exposure to Aboriginal languages. Positive effects have also been reported for health promoting behaviours such as children's access to daily physical activity and access to dental and health care. A study of ten AHS sites in Northwest Territories reported increased support and satisfaction among parents, and decreased grade repetition among participants (Western Arctic Aboriginal Head Start Council, 2006).

A comparative analysis of First Nations children living off reserve, Métis and Inuit children who had and had not participated in AHS found significant differences in AHSUNC children's feeling that culture is important to them, increased exposure to cultural activities such as telling stories, singing songs and participation in traditional or seasonal activities (O'Donnell, 2013). Non-formal reports and gatherings of Aboriginal organizations involved with children and families often identify AHS as the most positive program in Canada for Aboriginal families with young children: receiving funding to develop an AHS program is identified as a top priority in many communities.

Needs for knowledge development and mobilization. Performance measurement of AHS has mostly been at the level of individual sites and the regions. There is an outstanding need for a pan-regional or national study of the impacts of AHSUNC and AHSOR using a clinical-control, longitudinal research design and a limited set of high priority outcome measures commensurate with the emphasis on the program on child, family and community wellness and that are important to First Nations, Métis, and Inuit people. There has been little evidence to disseminate to influence policy or practice in community programs or within the Public Health Agency and Health Canada or among other federal, provincial and territorial government departments or national Aboriginal organizations. There is also an outstanding need for knowledge exchange and mobilization at regional and national levels. While this has been encouraged at the community and provincial level, there has not been funding for a national AHSUNC-AHSOR conference for several years.

Funding needs. In 2010-11, annual funding for AHSUNC was \$41.3 million (\$36.3 A-Base, \$5 million time-limited). In 2010-11, annual funding for AHSOR was \$59 million (\$46.5 million A-Base, \$7.5 million ongoing initiative, \$5 million time-limited, up to 2014-15) (Public Health Agency of Canada, 2012).

Comparing the reach of AHSUNC and AHSOR, based on the numbers of young Aboriginal children in 2006 (89,000 off reserve and 40,290 on reserve), AHSOR reaches a higher proportion in their target group. First Nations children living on reserve are four times as likely to participate in a federally-funded Aboriginal Head Start program compared with Aboriginal children living off reserve. While only 30% of young Aboriginal children on reserves, AHS is often the only early childhood program available to them. Seventy percent of young Aboriginal children live in urban and northern communities not on reserves. The AHSUNC program receives 40 per cent of the overall federal Aboriginal Head Start funding, while Aboriginal Head Start On Reserve program receives 60 per cent. A recent survey by FNIHB (2012) found

that AHSOR program staff experienced insufficient resources to achieve targets across all their program domains.

Overall, approximately 10% of Aboriginal children are able to access an AHSOR or AHSUNC program. A report by the Child and Youth Health Advisor to the former Minister of Health Tony Clement called for expansion of AHS to enable 25% coverage of Aboriginal children (Leitch, 2008).

The AHSUNC evaluation reported by the Public Health Agency of Canada (2012) noted that resource leveraging and partnerships at the site level are strengths of the program. However, short-term funding agreements and implementation of the National Strategic Fund in AHSUNC have been challenging. There is a need for long-term investment that grows to support the growth of the population of Aboriginal children and the number of families needing quality ECCE that also reflects the child's culture.

Training needs. AHS and other early childhood programs must, in most cases, be licensed by their provincial/territorial jurisdiction and must therefore maintain the correct number of certified early childhood educators and ratios of teachers to children. However, professional education to support attainment of ECE credentials for Aboriginal community members working in Aboriginal early childhood programs has been a persisting gap both on reserve and in urban and northern communities. Ever since AHS programs began, federal funds have been primarily for hard infrastructure and program operating costs. Staff training has consisted of piecemeal short courses by a variety of vendors that most often have no post-secondary accreditation and are often selling curriculum and materials. Many communities prefer Aboriginal educators in order to provide children with positive Aboriginal role models and to support the culture and language components of the programs. However, few Aboriginal educators have early childhood educator credentials. Hence, many programs operate with various interim permissions from the provincial or territorial government. Recruitment and retention of qualified early childhood educators – both Aboriginal and non-Aboriginal - especially in rural, remote and northern communities have been persistent problems. There is an outstanding need for federal investment in a system for providing high quality, accessible professional education for Aboriginal community members to meet local certification requirements as early childhood educators (e.g., one year post-secondary certificate or two-year diploma).

Coordination needs. Progress is being made in coordination of similar early childhood development programs within the Public Health Agency and First Nations and Inuit Health Branch of Health Canada (Ball & Moselle, 2012). However, coordination needs to be strengthened with other federal departments and the provinces and territories. In a cluster study of Health Canada's First Nations and Inuit Health Branch Child and Youth Programs (Health Canada, 2010) a key theme was the need for more integrated or unified approach to the Child and Youth program cluster as a whole. While levels of collaboration among programs were seen as good, barriers to improved collaboration were funding, issues related to the structure of the Child and Youth Cluster of programs, silo mentalities among practitioners, resource and staffing limitations, and unequal and inadequate community funding.

ECD Programs as sites of integration and inter-sectoral coordination

Some Aboriginal communities in Canada have demonstrated how early childhood development programs, such as AHS, can serve as focal points for coordinating the broader system of health and community programs in their communities (Ball, 2012). The research that led to the conceptualization of the 'Hook and Hub' approach (Ball, 2005) found that service delivery based on relationships of familiarity

increases participation by community members in programs such as parent support groups, mental health and substance abuse counselling, health education, preventive health services, and cultural and community events. This in turn enables early identification of health challenges as they emerge in children or their family members. It promotes social inclusion of children and families who may otherwise be isolated. 'Inter-sectoral' and 'integrated' programming can maximize health promoting impacts of programs for young Aboriginal children and families. These approaches can also optimize requirements for cultural safety and can have various capacity development and motivational impacts on communities (Ball, 2005).¹⁰

In order to address prominent wellness and education disparities among Aboriginal children, interventions must be informed by a good understanding of the determining factors *and* their interactions. ECCE practitioners touch some of these factors directly – at least the more proximal factors – in their everyday interactions with children and families. ECCE programs are sites where young children and their primary caregivers gather and form relationships of trust that have some continuity over time, creating a foundation for introducing health education, programs, and referrals, as well as a service memory among staff in the ECCE centre. There are low infrastructure demands of ECCE programs compared to health clinics or health centres. There is high potential for strengthening the capacity of community members to promote health, engage in early detection and monitoring of health conditions within individuals and in the environment. ECCE centres may be the only location in a community where itinerant service providers such as physicians, dental hygienists, and speech-language pathologists, may be able to meet with children and their primary caregivers with some reliability and consistency. ECCE programs can function as conduits for streamlined and reliable mechanisms for children and their primary caregivers to access an array of services, including services that target proximal determinants such as primary health care, screening and early interventions, and those that target distal determinants (e.g., housing, social support, mental health and addiction services for parents, job training and educational opportunities for parents, etc.). This is particularly important for responding to complex, often high-risk situations involving young Aboriginal children. Responsibility rests with organizations such as FNIHB, the Public Health Agency of Canada, and other organizations and partners in government to influence policy and funding to create the intersectoral partnerships necessary to impact on the more distal, though potent determinants.

A strong conceptual argument for integrated services centred in ECCE programs has been made in the literature on early childhood health and development on the basis of social-ecological analyses of how complex social systems affect child development and parenting (Lerner, Rothbaum, et al., 2002). These conceptual models draw on Bronfenbrenner's (1979) ecological model of development with multiple levels of influence on children and parents. Population health models (e.g., Irwin et al., 2007; Keating &

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- 10 Communities that have demonstrated the Hook and Hub approach have emphasized the following keys to success (Ball, 2005): Community members should be involved in program decision-making because they can identify prevalence and priority health issues and proximal and distal factors that may be over-determining the persistence or worsening of health problems, as well as potential protective factors that could be enhanced.
- Programming should be holistic, incorporating as many elements and associated practitioners into one or a small number of coordinated programs.
 - Fully credentialed post-secondary education for community members is foundational for successful, integrated, community-based programming. Community members must be fully qualified for a particular role and also supported to gain skills in a range of health support roles (e.g., developmental screening, speech-language facilitation, nutrition, basic vision and hearing screening, parent support, and referral/patient navigation).
 - Consider the family rather than the individual child as the recipient of programs and services.

Hertzman, 1999) also provide an important conceptual perspective in Canadian government policy. Pelletier and Corter (2006) discuss how calls for service integration in many service sectors and in many countries are driven by forces ranging from a search for efficiencies following government cuts to services, to accountability measures, to a quest for more effective and cohesive community-oriented services for children and families. Despite conceptual and practical rationales, empirical evidence of the value of integrating multi-services within or closely alongside Aboriginal ECCE programs in Canada is limited and inconclusive. Perhaps the best Canadian evidence on service integration through ECCE is longitudinal evaluation of the Better Beginnings Better Futures Project (Peters, Howell-Moneta, & Petrunka, 2012) and research on Best Start (Best Start Resource Centre, 2010).

At the present time in Canada, there is no known, empirically-tested program model that is sufficiently complete in its ability to address proximal determinants in a comprehensive and timely manner and also able to influence distal determinants through inter-sectoral coordination. Notwithstanding the lack of evidence of improved outcomes, several promising practices exist that enjoy positive community support and could be said to have certain 'face validity.' These innovations tend to be preschool or school-based with a community focus, such as Best Start, Toronto First Duty, and Better Beginnings Better Futures, and the Laichwiltach Family Life Society. These programs demonstrate the viability of early childhood and elementary school as staging grounds for health promotion and chronic disease prevention. Noticeably, school-based programs appear to reach more community members because school is universally available, whereas early childhood programs reach fewer community members because many families do not have access to preschool spaces. Conceptual models in other sectors, such as the Extended Chronic Care Model in BC, have mapped out and extended the macro components of a chronic care model for adults, taking a chronic disease management model and adding the components that are necessary to transform it into a prevention model. Efforts such as these, which are very familiar within the field of public health, push programs further upstream in order to influence causal factors related to health outcomes. This is worthwhile because many factors related to new incident cases of a chronic problem are the same factors that determine the degree of morbidity and mortality associated with it once it emerges.

Recommendations for Investments in Early Childhood Care and Education for young Aboriginal children

Canada's lackluster performance with regard to ameliorating Aboriginal child poverty, health-related inequities and high rates of placement in government care is abundantly evident based on a synthesis of available data. Tackling all of the equity gaps affecting outcomes for Aboriginal children will require policy change. Policies that ensure access by Aboriginal children to high quality, culturally appropriate ECCE can support children and families to achieve better outcomes. However, some promising approaches are being implemented, such as community-driven innovation in ECCE through the federal government supported AHS program.

Population data. There is an outstanding need for a scheduled system for disaggregated collection of information about First Nations, Métis and Inuit children's health contexts and health trajectories upon which to base programming decisions. The Aboriginal Children Survey and the Regional Health Survey are obvious choices for repeated measurement of indicators that are important to Aboriginal people who advised on creation of these tools. These data can track needs and progress on early childhood conditions, health, development and learning, access to programs, and outcomes, on a regional and national level. These data can monitor conditions including the reach of programs.

Knowledge development. Invest in high quality research assessing long-term outcomes of key programs such as AHSUNC and AHSOR, including child, family and community impacts, employing the methodologies and rigor of longitudinal cohort or clinical-control trial research designs. Development of this knowledge is needed to establish a case for long-term investments in programs that produce a lasting opportunity for Aboriginal children to enjoy their quality of life, achieve their developmental potential, and contribute to Canada's economic growth and development.

First Nations children on reserve. In light of alarming evidence of the dire conditions for First Nations children living on reserve, the amount and distribution of funds for ECCE and other early childhood programs should be assessed to ensure equitable and adequate support for all children to benefit from ECCE programs that serve as multi-service hubs and that can mitigate impacts of poverty and other quality of life deficits.

National Aboriginal Children's Commission. A mechanism is needed for monitoring the extent to which Canada is honouring its commitments to Aboriginal children - enshrined in various international declarations and conventions, in the Constitution, and in domestic action plans. Currently, Indian and Northern Affairs Canada has a First Nations Child and Family Services Advisory Committee which brings together First Nations leaders and provincial and territorial government officials to promote cooperative endeavours, particularly on issues pertaining to First Nations children's health and welfare. While this is appreciated, a legal framework and an independent national children's commission could monitor conditions for Aboriginal children, including cross-jurisdictional cooperation, help to track progress on key targets, identify opportunities to fill gaps, coordinate federal, provincial, and territorial policies that affect children, and bring legal action where necessary. These needed strategies were recommended in a 2007 Senate report (Government of Canada, Standing Senate Committee on Human Rights, 2007).

Aboriginal Head Start. Findings of an evaluation of AHSUNC conducted in 2010, along with other reported impacts of AHS, support this avenue to enhancing access by Aboriginal children and families to community-fitting, culturally-based early learning opportunities and other services. Current reach is limited and there is a continued and growing need for AHS spaces. Delivering the AHS program is an appropriate role for the federal government and aligns with the public health mandates of the Public Health Agency (AHSUNC) and Health Canada (AHSOR). Further, it is a positive instance of the federal government's direction to promote self-governance and self-determination among Aboriginal people. This program requires increased and long-term funding. The objectives and eligibility criteria for the National Strategic Fund for AHS should be reviewed.

Professional training. Accredited post-secondary education for community based educators in early childhood programs so that they are fully qualified to operate ECCE programs and to perform enhanced health promotion, organizational, and navigator functions in efforts to maximize the impacts of ECCD programs on Aboriginal children's wellness and success in school.

Culturally-based services. Cultural 'vitality' must be factored into ECCE services for Aboriginal children as one among many determinants of wellness and because robust, culturally-grounded identity can function as a global moderating factor to limit the impact of difficult-to-control distal factors. The critical role of culture as an enabling factor mediating health outcomes was highlighted in research by Hallett, Chandler and Lalonde (2007) on youth suicide, and in the wellness model and findings reported in the RHS (First Nations Governance Centre, 2012). It is also echoed in the Health Canada (2010) evaluation of CY programs: *"Areas that could be strengthened include: access to services for children with special needs and their families, support and information about child nutrition, and the incorporation and promotion of First Nations languages and cultures in Child and Youth programming"*(p. 14).

Integration/Intersectoral alignment. Significant advances in the ability of programs to impact critical distal determinants of Aboriginal children's outcomes require inter-sectoral coordination. Health Canada, the Public Health Agency of Canada, and other federal, provincial and territorial government agencies should explore the potential for maximizing the impact of early childhood programs such as AHSOR and AHSUNC by enabling them to become multi-service hubs. For example, ECCE programs could be strategically coordinated with the housing sector, the formal education sector, child welfare, social development, sanitation, and other actors and organizations that have a role in shaping the ecology and quality of life of Aboriginal children and their families. ECCE programs could be focal points for integrated health promotion/disease prevention services including health education, nutrition, dental hygiene, physical activity, emotional self-regulation/mental and spiritual wellness, coping skills, early identification, referral, after-care and community development efforts to improve Aboriginal children's overall quality of life. Research on *implementation* and *process*, as well as *outcomes*, should be built in to inform government policy and program decisions.

Conclusion

Aboriginal children are the fastest growing segment of the population of children in Canada. Their wellness is a bellwether of the health of our nation. The Prime Minister's Apology in 2008 did not, as some Canadians hoped, put Aboriginal suffering as a result of colonial government policies and actions, in the past. The harms done through the Residential Schools for First Nations and Inuit children linger on in the memories and family lives of many Aboriginal people, and their difficulties are often used as grounds for disparagement on the parts of some non-Aboriginal Canadians. As the outpouring of concerned response from Aboriginal people to the Apology underscored, achieving equity and dignity for Aboriginal children and families is going to take time. Closing gaps will require collective efforts including ongoing public investment in programmatic efforts designed and implemented in partnership with Aboriginal governments, community groups and organizations in ways that break down barriers to ensuring quality of life for Aboriginal children and build on the attributes and strengths of Aboriginal communities and cultures. Ensuring access to culturally-based, holistic ECCE programs is one cornerstone of success for young Aboriginal children and families.

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